*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
March 6, 2025

Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

RE: CCN: 245281
Cycle Start Date: January 27, 2025

Dear Administrator:

On March 5, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

*An equal opportunity employer.*

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

March 6, 2025

Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

Re: Reinspection Results
Event ID: 292412

Dear Administrator:

On March 5, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 11, 2025

Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

RE: CCN: 245281
Cycle Start Date: January 27, 2025

Dear Administrator:

On January 27, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 27, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

## INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

## INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Electronically delivered
February 11, 2025

Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, Box 129
Barnesville, MN 56514

Re: State Nursing Home Licensing Orders
Event ID: 292411

Dear Administrator:

The above facility was surveyed on January 27, 2025 through January 27, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245281 | A. BUILDING ______ B. WING ______ | C 01/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VALLEY CARE AND REHAB LLC | 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On 1/27/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaint was reviewed: H52815820C (MN00110056) with a deficiency cited at F600.<br><br>As a result of the investigation a deficiency cited at F609<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. | F 600 | | 1/27/25 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/20/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600 Continued From page 1

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to protect the resident's right to be free from mental abuse for 1 of 1 resident (R1) reviewed for abuse when staff, while providing cares, took a photo of R1 who was covered in feces and posted the photo to social media.

Findings include:

Nursing Assistant (NA)-A's Employee Acknowledgment dated and signed on 6/23/21, identified she had received, read, and understood and comply with the Valley Care and Rehab's Social Media policy. Any questions regarding this policy would be addressed by human resources. A violation of Social Media policy would result in disciplinary action and/or termination.

Nursing assistant (NA)-A's personnel file identified the following:

-On 7/19/21, director of nursing (DON) was made aware NA-A had utilized snapchat (social media) during work without regard as to who was in the background. NA-A admitted she had used her phone on the shift during the night. She verbalized understanding of phone expectations and when/where it was appropriate to use.

-On 9/14/23, NA-A had posted pictures on social media of herself with diarrhea on covered pants

F 600

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. This plan is submitted as evidence of our compliance. Governing agencies in charge of regulatory compliance and the protection of vulnerable adults have not indicated that the individual will be held responsible for their actions.

F600 – Freedom from Abuse, Neglect, and Exploitation

WL38 – facility failed to ensure that the resident remained free from mental abuse.

• Plan for correcting the specific deficiency – addressing the process that led to the deficiency

This facility continues to ensure that all residents have the right to be free from all forms of abuse.

F 600

Continued From page 2

in the hopper room (dirty utility room) with a caption "what a shitty Friday" and a thumbs up. She was informed even though the picture did not have personal information, the resident family could probably identify or suspect, with the style and color of the pants. She was informed this displayed unprofessional, and many companies would consider posting a picture such this to any online platform would be grounds for termination. She did not agree it was unprofessional and only wanted to know who had shown it to the facility. She was informed by the facility it was expected she stop posting things of that nature from this facility.

According to the State Operations Manual Appendix PP dated 8/8/24, identified the definition of mental abuse includes abuse that was facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans, or humiliates a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status, include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a

F 600

Facility policies and procedures for all forms of abuse, the prevention of, and the reporting of abuse, neglect, and exploitation were reviewed. Facility social media and personal electronic device policies and procedures were reviewed. The facility's abuse prevention and social media policies were found in compliance with federal regulations.

NA-A had received, read, and signed understanding of Valley Care and Rehab's Social Media policy.

The facility had maintained signage entering the resident care areas notifying all staff that cell phones were prohibited.

The facility had ensured that all staff upon hire and annually receive education regarding abuse prevention, social media, and facility policy on personal electronic devices.

All facility processes found to be compliant with state and federal regulations.

- Procedure for implementing the plan

All residents are vulnerable adults and have the potential to be affected.

The facility took immediate action when made aware of the incident. Facility wide corrective actions completed by Monday 20. Corrective actions include:
- The employee involved in this incident was terminated per our social media

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| VALLEY CARE AND REHAB LLC | 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 |

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F 600 Continued From page 3
resident to use inappropriate language, and showing the resident in a compromised position.

R1's quarterly Minimum Data Set (MDS) dated 11/28/24, identified moderately impaired cognition without behaviors. He required supervision with sit to stand, chair to bed transfers, and ambulation up to 10 feet, partial/moderate assistance with upper body dressing, personal hygiene, substantial/maximal assistance with lower body dressing, roll left/right in bed, dependent upon staff for toileting hygiene, and used a walker and wheelchair for mobility. He had an indwelling urinary catheter and colostomy (a surgical procedure that creates an opening in the abdomen for feces waste to exit the body). R1's diagnoses included neurogenic (lack of bladder control due to brain, spinal cord, or nerve problems), arthritis, and depression.

R1's care plan dated 12/12/24, identified he had an assisted daily living (ADL) self-care performance deficit related to supra pubic (empties the bladder through an incision in the abdomen instead of a tube in the urethra) urinary catheter and colostomy, and was dependent upon staff to manage these external devices and provide assistance with toilet hygiene.

Review of nursing assistant schedule from 1/13/25 through 1/26/25, identified NA-A was scheduled to work on 1/17/25, Friday 4:00 p.m. to 9:30 p.m.

Facility investigation report dated 1/18/25, identified DON received a telephone call from a police department and a phone text message from a citizen in town regarding actions by one of the staff members of the facility. The picture

F 600
policy, which prohibits taking pictures of any type and posting on any social media site. Personal choice.
- All staff received immediate re-education by the Director of Nursing and Administrator about the facility's Abuse Prevention policies, Social Media policy, and the seriousness of any breach of these policies.
- The family of R1 was notified of the incident.

The Social Service Designee or designee will continue to provide yearly education to all staff regarding abuse and social media, which is maintained in Healthcare Academy and on-site Education binder. All staff will continue to be educated on the seriousness of any breach of these policies.

The Social Service Designee or designee will continue to provide copies of abuse and social media policies to all new hires. All new hires will continue to be educated on the seriousness of any breach of these policies. New hire education will be maintained in their personnel files.

The facility will continue to have signs posted indicating: No Cell Phones Allowed Beyond this Point.

No systemic changes are required currently.

- Monitoring procedure to ensure plan is effective & that the deficiency remains corrected & compliant. Title of the person

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 600 | Continued From page 4<br>showed a resident's right hand with liquid stool on it, a catheter bag on the floor with tubing attached to a stat lock (a cassette that held the urinary catheter tubing in place) and the resident's colostomy bag which had leaked. The caption to the photo was "my 13th reason" name at the top of photo identified a name of social media account and below it was NA-A's name. The post identified the staff member as NA-A. DON spoke with NA-A and she stated she had not made any snaps today and once she was informed of the photo evidence she confessed and told DON she had posted something to her private story, had taken it down, but not soon enough, when she realized it was inappropriate. She had a rough night prior to her shift and had influenced her decision making. NA-A had received verbal warnings in July 2021 and 2023 regarding cell phone use and social media. Education regarding facility policy on social media and electronic devices were reviewed with her and verbalized understanding. It was determined that despite the education, she lacked understanding of the seriousness of this incident as was at risk for repeat offenses, employment was terminated on 1/21/25. The photographs contained no identifying information to breach Health Insurance Portability and Accountability Ace of 1996 (HIPAA) (prohibiting the disclosure of protected health information). The photograph was not explicit in nature. The resident did not have any verbal/nonverbal distress to the incident. All resident needs were met, and it was not identified that NA-A acted in a willful manner. There was no physical confinement, punishment, or intimidation identified. DON and interdisciplinary team (IDT) determined the incident was poor judgment it would not be reported. Strict enforcement of facility cell phone policy will be implemented to | F 600 | responsible for implementing the plan of correction<br><br>DON or designee will audit staff for personal electronic devices every shift for one week. DON or designee will complete random unannounced audits 2x a week for 30 days or until 100% compliance is achieved. All audit outcomes shall be presented to the QAPI committee. The committee will determine if further monitoring is required.<br><br>• Date the facility will be in complete compliance<br><br>Corrective actions completed by January 27, 2025. | |

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| F 600 | Continued From page 5<br>protect residents, moving forward.<br><br>During an interview on 1/24/25 at 1:00 p.m. complainant (C) stated NA-A had taken a picture of a resident who sat at edge of bed after the colostomy bag had exploded. The picture showed stool on the resident hand and leg and caption on the picture was 13 Reasons why. C stated she must have had a crappy day and most likely the reason she posted it. C stated this was an invasion of privacy and a HIPAA violation.<br><br>During review on 1/26/25 of a photo taken by NA-A and posted to social media, the photo identified a person sitting on the edge of a bed, with the right lower arm positioned on a mattress and the right hand hung over the edge with dark golden mushy yellow substance (appeared to be stool) located on the thumb, pointer and middle fingers. The person's right leg was bare from the center of the upper thigh down to the upper calf. Located on the middle top part of the right thigh was a stat lock that held the urinary catheter tubing in place with tubing attached to the catheter bag that was located on the floor folded over. The person had a colostomy bag that hung down from their abdomen area to the right upper thigh area that contained the same stool substance located on the fingers. Top of colostomy bag was covered with material. The end of the colostomy bag clamp appeared to have let loose, and stool was located on the bed sheet off to the right side of the person and had run down the side of the mattress. There was a moderate amount of stool on the floor underneath the person's right leg. Written towards the bottom of the picture was "my 13th reason" and at the top of the picture identified "2 hours ago by NA-A's name". | F 600 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| VALLEY CARE AND REHAB LLC | 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 |

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| F 600 | Continued From page 6 | F 600 | | |

During an interview on 1/27/25 at 12:12 p.m. NA-A stated she had been terminated, was wrongful just from an incident with her cell phone. She had used her cell phone while she cared for a resident in his room. R1's colostomy bag had exploded, she had taken a picture of the feces, his hand, colostomy, the bed, floor, and part of his bare leg. She did not think family could have identified him in the picture there was not a picture of his face. She posted the picture of R1 on 1/17/25, while she was at work on a private social media site snapchat with only a handful of people on it. She removed it an hour later because she was ashamed, embarrassed, was unprofessional, and she let her emotions get the best of her. She knew what she was doing, did it anyway, and regrets it. R1 was not asked if the picture could be taken nor was, he aware it was taken, he had dementia. She said if R1 knew it had been taken and posted on social media it would have affected him negatively, he would have felt embarrassed and was an invasion of his privacy. NA-A stated this would not be a HIPPA violation because there were not any specific identifiers therefore, unable to identify him. On her private social media site there were at least 15 people and at least two of them worked with her at this facility. She stated only one resident currently had a colostomy and never thought about those that worked with her, and they could have identified him. Staff were allowed to have had their cell phones and used them while they worked at the facility with residents. She was unable recall any write ups in the past regarding issues with her use of cell phone at work and social media posts.

During an interview on 1/27/25 at 3:11 p.m. family

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| F 600 | Continued From page 7<br>member (FM) stated R1 was a very private person, made sure his colostomy and urinary catheter bags were always covered. R1 was consciousness and did not want them exposed. If a picture was taken of anyone for that matter and posted on social media even without a face would be demeaning and humiliating. R1 did not know this happened but if he did, it would have bothered him and was an invasion of his privacy.<br><br>During an interview on 1/27/25 at 3:37 p.m. DON stated 2021 NA-A had taken a picture with her cell phone along with another staff member at work and there was a resident behind her. She stated 2023 NA-A had taken a picture with her cell phone in a utility room by herself, held up resident's pants soiled with stool, and posted it to social media. Education was provided and included facility policy and expectations. DON stated on 1/18/27 she was made aware by a police officer (PO) on 1/17/25, NA-A had taken a picture of R1 and posted it onto social media for anyone on her account to see, unsure of how many but was too many. R1 was not aware of what happened, had a poor memory and was not interviewable. The facility had a cell phone policy in place since she became DON (2015), and staff were expected to leave their cell phones in the staff locker room while on the floor working with residents. DON stated NA-A made a poor choice in the moment, had taken a photo of a resident, and posted it to social media which affects privacy and dignity. The incident was not filed with SA, the resident was not identifiable in the photo. She stated NA-A was immature, knew what she did was wrong, used poor decision making that led her to take the picture. The incident was not a willful act and was not done to hurt or embarrass R1. A reasonable person would been upset about | F 600 | | |

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| F 600 | Continued From page 8<br>this and asked why are you taking a picture of my colostomy. The picture was not taken to complete cares or replace the appliance and was not necessary. Any normal person would have been embarrassed, humiliated, and felt it was demeaning.<br><br>During an interview on 1/27/25 at 4:07 p.m. administrator stated on 1/18/25, he was made aware of the incident when NA-A had taken a picture of a resident and posted it on social media. The incident was not reported to the SA, did not meet the reportable guidelines of the algorithm. The person in the photo was unidentifiable. This employee had worked at other faculties and not sure where the photo was taken, location, or which employer. He was aware of two other incidents where NA-A used her cell phone at work and posted pictures to social media. He stated staff were expected to leave their cell phones in the locker room while at work and a sign was posted by the back door for years, no cell phones beyond these doors. Immediate action was taken to ensure that there was no other staff with personal devices on the floor, provider and family notified, educated staff, and terminated staff involved. The resident was not made aware of this incident per family request.<br><br>Facility policy Free from Abuse and Neglect dated 11/1/22, identified the facility will ensure that each resident has the right to be free form abuse, neglect, and corporal punishment of any type by anyone. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, and mental abuse including abuse facilitated or enabled using technology. Willful was defined as the | F 600 | | |

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| F 600 | Continued From page 9<br>individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental and verbal abuse was defined as verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.<br><br>Facility Social Media Policy dated 11/1/24, identified Valley Care and Rehab respects the desire of employees to use social media including but not limited to all social networking communications, electronic communications, and electronic information for personal expression. However, employees' use of social media can pose risks to the residents' confidential, proprietary and sensitive information, can harm the facility: reputation in the community, expose facility to discrimination and harassment claims, jeopardize facility compliance with business rules and laws including but not limited to the Health Insurance Portability and Accountability Act (HIPPA) and related laws and regulations protecting residents' protected health information (PHI). Electronic devices were defined as any device used for electronic communication or electronic information included: computers, laptops, tablets, digital cameras, video recorders, fax machines, copiers, scanners, telephone system, smart phones, cell phones, and pagers. Employees are absolutely prohibited from using social media in any way that would violate HIPPA or otherwise disclose or compromise residents' public health information (PHI). This includes but is not limited to the following: Do not use social media to post, upload, send or otherwise share or disclose a photo or video of any resident without prior written permission of the resident or the resident's authorized agent as required by | F 600 | | |

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| F 600 | Continued From page 10<br>applicable law. You must use Valley Care and Rehab's authorization form to obtain such prior written permission. This prohibition includes photos and videos where the resident is not easily identifiable (e.g., a photo of the resident's hand, a close-up photo of any part of a resident's body, or a photo of the back of a resident in the far background of the photo). It also includes photos or video where the resident is easily identifiable, whether in the photo or video itself or through a caption. Personal use of social media is never permitted on working time.<br><br>Facility resident Consent to Photograph dated 1/1/25, located in the resident admission packet, identified I hereby authorize consent to the making of photographs of me while I am a resident at Valley Care Rehab. I understand that the photographs maybe made by my attending physician or an employee of the facility. I understand that such photographs maybe used for treatment purposes, including the assessment and evaluation of my wound(s). I understand that these images will be stored in a secure manner and will protect privacy and that they will be kept for the time required by law. | F 600 | | |
| F 609<br>SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 | F 609 | | 1/30/25 |

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| F 609 | Continued From page 11<br>hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to immediately report no later than two hours, an allegation of abuse to the State Agency (SA) for 1 of 1 residents (R1) reviewed for abuse.<br><br>Findings include:<br><br>Nursing Assistant (NA)-A's Employee Acknowledgment dated and signed on 6/23/21, identified she had received, read, and understood and comply with the Valley Care and Rehab's Social Media policy. Any questions regarding this policy would be addressed by human resources. A violation of Social Media policy would result in disciplinary action and/or termination.<br><br>NA-A's personnel file identified previous write-ups | F 609 | F609 – Reporting Reasonable Suspicion of a Crime & Alleged Violation<br><br>WL38 – facility failed to timely report alleged violation involving significant bodily injury.<br><br>• Plan for correcting the specific deficiency – addressing the process that led to the deficiency<br><br>Immediate actions taken including investigation of allegation involving R-1 were completed with findings. R-1 care plan, current orders, and progress notes have been reviewed. Ongoing monitoring of R-1 mood and psychosocial wellbeing completed and remained at baseline. | |

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completed on the following dates:

-On 7/19/21, director of nursing (DON) was made aware NA-A had utilized snapchat (social media) during work without regard as to who was in the background. NA-A admitted she had used her phone on the shift during the night. She verbalized understanding of phone expectations and when/where it was appropriate to use.

-On 9/14/23, the writer had been made aware NA-A had posted pictures on social media of herself with diarrhea on covered pants in the hopper room (dirty utility room) with a caption "what a shitty Friday" and a thumbs up. She was informed even though the picture did not have personal information, the resident family could probably identify or suspect, with the style and color of the pants. She was informed this displayed unprofessional, and many companies would consider posting a picture such this to any online platform would be grounds for termination. She did not agree it was unprofessional and only wanted to know who had shown it to the writer. She was informed by writer it was expected she stop posting things of that nature from this facility.

According to the State Operations Manual Appendix PP dated 8/8/24, identified the definition of mental abuse includes abuse that was facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident, regardless of whether the resident

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Primary physician, Medical Director, and family were notified.

Facility policies and procedures for the reporting of abuse, neglect, and exploitation were reviewed.

- Procedure for implementing the plan

All residents are at risk of being potentially affected by this practice. The Administrator and Director of Nursing reviewed all incidents and progress notes for the last 30 days to identify any incidents to ensure reporting was completed if appropriate.

Regulations regarding reporting requirements for abuse reviewed by DON, ADON, and Administrator to assure key personnel understand the importance of immediate reporting and investigation of incidents involving all forms of abuse. All facility staff were re-educated on abuse reporting policies and procedures.
CMS Exhibits 358 and 359 implemented for a concise area to document completion of steps in the investigation reporting timeline and prevent omission of a step.

All recent resident incidents have been reviewed by DON, ADON, and Administrator to ensure accurate reporting of alleged incidents resulting in abuse, neglect, and exploitation, or serious bodily injury.

- Monitoring procedure to ensure plan

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| F 609 | Continued From page 13<br>provided consent and regardless of the resident's cognitive status. include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position.<br><br>R1's quarterly Minimum Data Set (MDS) dated 11/28/24, identified moderately impaired cognition without behaviors. He required supervision with sit to stand, chair to bed transfers, and ambulation up to 10 feet, partial/moderate assistance with upper body dressing, personal hygiene, substantial/maximal assistance with lower body dressing, roll left/right in bed, dependent upon staff for toileting hygiene, and used a walker and wheelchair for mobility. He had an indwelling urinary catheter and colostomy (a surgical procedure that creates an opening in the abdomen for waste to exit the body). R1's diagnoses included neurogenic (lack of bladder control due to brain, spinal cord, or nerve problems), arthritis, and depression.<br><br>R1's care plan dated 12/12/24, identified he had an assisted daily living (ADL) self-care performance deficit related to supra pubic (empties the bladder through an incision in the abdomen instead of a tube in the urethra) urinary catheter and colostomy, and was dependent upon staff to manage these external devices and | F 609 | is effective & that the deficiency remains corrected & compliant. Title of the person responsible for implementing the plan of correction<br><br>Administrator or designee will conduct audits weekly for four weeks and twice a month for two months to ensure incidents are reported per policy and procedures. All audit outcomes shall be presented to the QAPI committee monthly for three months. The committee will determine if further monitoring is required.<br><br>• Date the facility will be in complete compliance<br><br>Corrective actions completed by January 30, 2025. | |

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provide assistance with toilet hygiene.

Review of nursing assistant schedule from 1/13/25 through 1/26/25, identified NA-A was scheduled to work on 1/17/25, Friday 4:00 p.m. to 9:30 p.m.

Facility investigation report dated 1/18/25, identified DON received a telephone call from Barnesville Police department and a phone text message from a citizen in Barnesville regarding actions by one of the staff members of the facility. The picture showed a resident's right hand with liquid stool on it, a catheter bag on the floor with tubing attached to a stat lock (a cassette that held the urinary catheter tubing in place) and the resident's colostomy bag which had leaked. The caption to the photo was "my 13 th reason" name at the top of photo identified a name of social media account and below it was NA-A's name. The PO identified the staff member as NA-A. DON spoke with NA-A and she stated she had not made any snaps today and once she was informed of the photo evidence she confessed and told DON she had posted something to her private story, had taken it down, but not soon enough, when she realized it was inappropriate. She had a rough night prior to her shift and had influenced her decision making. NA-A had received verbal warnings in July 2021 and 2023 regarding cell phone use and social media. Education regarding facility policy on social media and electronic devices were reviewed with her and verbalized understanding. It was determined that despite the education, she lacked understanding of the seriousness of this incident as was at risk for repeat offenses, employment was terminated on 1/21/25. The photographs contained no identifying information to breach

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| F 609 | Continued From page 15<br>Health Insurance Portability and Accountability Ace of 1996 (HIPAA) (prohibiting the disclosure of protected health information). The photograph was not explicit in nature. The resident did not have any verbal/nonverbal distress to the incident. All resident needs were met and it was not identified that NA-A acted in a willful manner. There was no physical confinement, punishment, or intimidation identified. DON and interdisciplinary team (IDT) determined the incident was poor judgment it would not be reported. Strict enforcement of facility cell phone policy will be implemented to protect residents, moving forward.<br><br>During an interview on 1/24/25 at 1:00 p.m. complainant (C) stated NA-A had taken a picture of a resident who sat at edge of bed after the colostomy bag had exploded. The picture showed stool on the resident hand and leg and caption on the picture was 13 Reasons why. C stated she must have had a crappy day and most likely the reason she posted it. C stated this was an invasion of privacy and a HIPAA violation.<br><br>During review of a photo attachment on 1/26/25 submitted with complaint identified a person sat with right lower arm positioned on a mattress and right hand hung over the edge with dark golden mushy yellow substance (appeared to be stool) located on the thumb, pointer and middle fingers. The person's right leg was bare from the center of the upper thigh down to the upper calf. Located on the middle top part of the right thigh was a stat lock that held the urinary catheter tubing in place with tubing attached to the catheter bag that was located on the floor folded over. The person had a colostomy bag that hung down from their right upper thigh area that contained the same stool | F 609 | | |

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substance located on the fingers. Top of colostomy bag was covered with material. The end of the colostomy bag clamp appeared to have let loose, and stool was located on the bed sheet off to the right side of the person and had ran down the side of the mattress. There was a moderate amount of stool on the floor underneath the person's right leg. Written towards the bottom of the picture was "my 13th reason" and at the top of the picture identified "2 hours ago by NA-A's name".

During an interview on 1/27/25 at 11:07 a.m. licensed practical nurse (LPN)-A stated taking photos of residents and posting them on social media would be considered very serious HIPPA violation, and an invasion of their privacy. She had told staff in report cell phone must be placed in the staff locker room and were not allowed out on the floor while they worked. The facility had posted a yellow sign a long time ago on the door by the kitchen area that indicated: No Cell Phones Allowed Beyond this Point.

During an interview on 1/27/25 at 11:17 a.m. NA-B stated staff were not allowed to have their cell phones on them while on duty and caring for residents. Residents needed to be protected and it would not be ok to take pictures and post them on social media, would be considered a HIPPA violation and most likely embarrass the resident for sure.

During an interview on 1/27/25 at 12:12 p.m. NA-A stated she had been terminated, was wrongful just from an incident with her cell phone. She had used her cell phone while she cared for a resident in his room. R1's colostomy bag had exploded, she had taken a picture of the feces,

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his hand, colostomy, the bed, floor, and part of his bare leg. She did not think family could have identified him in the picture there was not a picture of his face. She posted the picture of R1 on 1/17/25, while she was at work on a private social media site snapchat with only a handful of people on it. She removed it an hour later because she was ashamed, embarrassed, was unprofessional, and she had let her emotions get the best of her. She knew what she was doing, did it anyway, and regrets it. R1 was not asked if the picture could be taken nor was he aware it was taken, he had dementia. She said if R1 knew it had been taken and posted on social media it would have affected him negatively, he would feel embarrassed and was an invasion of his privacy. NA-A stated this would not be a HIPPA violation because there were not any specific identifiers therefore, unable to identify him. On her private social media site there were at least 15 people and at least two of them worked with her at this facility. She stated only one resident currently had a colostomy and never though about those that worked with her, they could have identified him. Staff were allowed to have had their cell phones and used them while they worked at the facility with residents. She was unable to recall any write ups in the past regarding issues with her use of cell phone at work and social media posts.

During an interview on 1/27/25 at 3:11 p.m. family member (FM) stated R1 was a very private person, made sure his colostomy and urinary catheter bags were always covered. R1 was consciousness and did not want them exposed. If a picture was taken of anyone for that matter and posted on social media even without a face would be demeaning and humiliating. R1 did not know this happened but if he did, it would have

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|---|---|
| VALLEY CARE AND REHAB LLC | 600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514 |

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bothered him and was an invasion of his privacy.

During an interview on 1/27/25 at 3:37 p.m. DON stated 2021 NA-A had taken a picture with her cell phone along with another staff member at work and there was a resident behind her. She stated 2023 NA-A had taken a picture with her cell phone in a utility room by herself, held up resident's pants soiled with stool, and posted it to social media. Education was provided and included facility policy and expectations. DON stated on 1/18/27 she was made aware by a police officer (PO) on 1/17/25, NA-A had taken a picture of R1 and posted it onto social media for anyone on her account to see, unsure of how many but was too many. R1 was not aware of what happened, had a poor memory and was not interviewable. The facility had a cell phone policy in place since she became DON (2015) and staff were expected to leave their cell phones in the staff locker room while on the floor working with residents. DON stated NA-A made a poor choice in the moment, had taken a photo of a resident and posted it to social media which affects privacy and dignity. The incident was not filed with SA, the resident was not identifiable in the photo. She stated NA-A was immature, knew what she did was wrong, used poor decision making that led her to take the picture. The incident was not a willful act and was not done to hurt or embarrass R1. A reasonable person would been upset about this and asked why are you taking a picture of my colostomy. The picture was not taken to complete cares or replace the appliance and was not necessary. Any normal person would have been embarrassed, humiliated and felt it was demeaning.

During an interview on 1/27/25 at 4:07 p.m.

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| F 609 | Continued From page 19 | F 609 | | |

administrator stated on 1/18/25, he was made aware of the incident when NA-A had taken a picture of a resident and posted it on social media. The incident was not reported to the SA, did not meet the reportable guidelines of the algorithm. The person in the photo was unidentifiable. This employee had worked at other faculties and not sure where the photo was taken, location, or which employer. He was aware of two other incidents where NA-A used her cell phone at work and posted pictures to social media. He stated staff were expected to leave their cell phones in the locker room while at work and a sign was posted by the back door for years, no cell phones beyond these doors. Immediate action was taken to ensure that there was no other staff with personal devices on the floor, provider and family notified, educated staff, and terminated staff involved. The resident was not made aware of this incident per family request.

Facility Combined Federal and State Bill of Rights last revised 2/1/17, identified each resident must be treated with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his/her quality of life. The resident has the right to be free from abuse, neglect and misappropriation of resident property, and exploitation of this subject. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

Facility policy Free from Abuse and Neglect dated 11/1/22, identified the facility will ensure that each resident has the right to be free form abuse, neglect, and corporal punishment of any type by anyone. Instances of abuse of all residents, irrespective of any mental or physical condition,

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| F 609 | Continued From page 20<br>cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, and mental abuse including abuse facilitated or enabled using technology. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental and verbal abuse was defined as verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.<br><br>Facility policy titled Reporting of Reasonable Suspicion of a Crime/Reporting of Alleged Violations dated 2/14/24, identified:<br><br>-What should be reported: all alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property.<br>-Who is required to report: the facility.<br>-To whom: Facility administrator, Office of Health Facility Complaints (OHFC), Clay County Social Services, Law Enforcement, Attending Physician, and Resident's Representative.<br>-When: All alleged violations. Immediately, but not later than 2 hours. If alleged violation involves abuse or results in serious bodily injury.<br><br>Facility Social Media Policy dated 11/1/24, identified Valley Care and Rehab respects the desire of employees to use social media including but not limited to all social networking communications, electronic communications, and electronic information for personal expression. However, employees' use of social media can pose risks to the residents' confidential, proprietary and sensitive information, can harm the facility: reputation in the community, expose | F 609 | | |

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| F 609 | Continued From page 21<br>facility to discrimination and harassment claims, jeopardize facility compliance with business rules and laws including but not limited to the Health Insurance Portability and Accountability Act (HIPPA) and related laws and regulations protecting residents' protected health information (PHI). Electronic devices were defined as any device used for electronic communication or electronic information included: computers, laptops, tablets, digital cameras, video recorders, fax machines, copiers, scanners, telephone system, smart phones, cell phones, and pagers. Employees are absolutely prohibited from using social media in any way that would violate HIPPA or otherwise disclose or compromise residents' public health information (PHI). This includes but is not limited to the following: Do not use social media to post, upload, send or otherwise share or disclose a photo or video of any resident without prior written permission of the resident or the resident's authorized agent as required by applicable law. You must use Valley Care and Rehab's authorization form to obtain such prior written permission. This prohibition includes photos and videos where the resident is not easily identifiable (e.g., a photo of the resident's hand, a close up photo of any part of a resident's body, or a photo of the back of a resident in the far background of the photo). It also includes photos or video where the resident is easily identifiable, whether in the photo or video itself or through a caption. Personal use of social media is never permitted on working time. | F 609 | | |

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| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:
On 1/27/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and

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| 2 000 | Continued From page 1 | 2 000 | | |

identify the date when they will be completed.

The following complaint was reviewed.

H52815820C (MN00110056) with a licensing order issued at 1980.

Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of

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| 2 000 | Continued From page 2<br>state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |
| 21980 | MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults<br><br>Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:<br><br>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or<br>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).<br>(b) A person not required to report under the provisions of this section may voluntarily report as described above.<br>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.<br>(d) Nothing in this section shall preclude a | 21980 | | 1/30/25 |

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| 21980 | Continued From page 3<br>reporter from also reporting to a law enforcement agency.<br>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to immediately report no later than two hours, an allegation of abuse to the State Agency (SA) for 1 of 1 residents (R1) reviewed for abuse.<br><br>Findings include:<br><br>Nursing Assistant (NA)-A's Employee Acknowledgment dated and signed on 6/23/21, identified she had received, read, and understood and comply with the Valley Care and Rehab's Social Media policy. Any questions regarding this policy would be addressed by human resources. A violation of Social Media policy would result in disciplinary action and/or termination. | 21980 | F609 – Reporting Reasonable Suspicion of a Crime & Alleged Violation<br><br>WL38 – facility failed to timely report alleged violation involving significant bodily injury.<br><br>• Plan for correcting the specific deficiency – addressing the process that led to the deficiency<br><br>Immediate actions taken including investigation of allegation involving R-1 were completed with findings. R-1 care plan, current orders, and progress notes have been reviewed. Ongoing monitoring of R-1 mood and psychosocial wellbeing | |

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Continued From page 4

NA-A's personnel file identified previous write-ups completed on the following dates:

-On 7/19/21, director of nursing (DON) was made aware NA-A had utilized snapchat (social media) during work without regard as to who was in the background. NA-A admitted she had used her phone on the shift during the night. She verbalized understanding of phone expectations and when/where it was appropriate to use.

-On 9/14/23, the writer had been made aware NA-A had posted pictures on social media of herself with diarrhea on covered pants in the hopper room (dirty utility room) with a caption "what a shitty Friday" and a thumbs up. She was informed even though the picture did not have personal information, the resident family could probably identify or suspect, with the style and color of the pants. She was informed this displayed unprofessional, and many companies would consider posting a picture such this to any online platform would be grounds for termination. She did not agree it was unprofessional and only wanted to know who had shown it to the writer. She was informed by writer it was expected she stop posting things of that nature from this facility.

According to the State Operations Manual Appendix PP dated 8/8/24, identified the definition of mental abuse includes abuse that was facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident, regardless of whether the resident

21980

completed and remained at baseline. Primary physician, Medical Director, and family were notified.

Facility policies and procedures for the reporting of abuse, neglect, and exploitation were reviewed.

- Procedure for implementing the plan

All residents are at risk of being potentially affected by this practice. The Administrator and Director of Nursing reviewed all incidents and progress notes for the last 30 days to identify any incidents to ensure reporting was completed if appropriate.

Regulations regarding reporting requirements for abuse reviewed by DON, ADON, and Administrator to assure key personnel understand the importance of immediate reporting and investigation of incidents involving all forms of abuse. All facility staff were re-educated on abuse reporting policies and procedures.
CMS Exhibits 358 and 359 implemented for a concise area to document completion of steps in the investigation reporting timeline and prevent omission of a step.

All recent resident incidents have been reviewed by DON, ADON, and Administrator to ensure accurate reporting of alleged incidents resulting in abuse, neglect, and exploitation, or serious bodily injury.

- Monitoring procedure to ensure plan is effective & that the deficiency remains

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| 21980 | Continued From page 5<br><br>provided consent and regardless of the resident's cognitive status. include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position.<br><br>R1's quarterly Minimum Data Set (MDS) dated 11/28/24, identified moderately impaired cognition without behaviors. He required supervision with sit to stand, chair to bed transfers, and ambulation up to 10 feet, partial/moderate assistance with upper body dressing, personal hygiene, substantial/maximal assistance with lower body dressing, roll left/right in bed, dependent upon staff for toileting hygiene, and used a walker and wheelchair for mobility. He had an indwelling urinary catheter and colostomy (a surgical procedure that creates an opening in the abdomen for waste to exit the body). R1's diagnoses included neurogenic (lack of bladder control due to brain, spinal cord, or nerve problems), arthritis, and depression.<br><br>R1's care plan dated 12/12/24, identified he had an assisted daily living (ADL) self-care performance deficit related to supra pubic (empties the bladder through an incision in the abdomen instead of a tube in the urethra) urinary catheter and colostomy, and was dependent upon staff to manage these external devices and provide assistance with toilet hygiene. | 21980 | corrected & compliant. Title of the person responsible for implementing the plan of correction<br><br>Administrator or designee will conduct audits weekly for four weeks and twice a month for two months to ensure incidents are reported per policy and procedures. All audit outcomes shall be presented to the QAPI committee monthly for three months. The committee will determine if further monitoring is required.<br><br>• Date the facility will be in complete compliance<br><br>Corrective actions completed by January 30, 2025. | |

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| 21980 | Continued From page 6 | 21980 | | |

Review of nursing assistant schedule from 1/13/25 through 1/26/25, identified NA-A was scheduled to work on 1/17/25, Friday 4:00 p.m. to 9:30 p.m.

Facility investigation report dated 1/18/25, identified DON received a telephone call from Barnesville Police department and a phone text message from a citizen in Barnesville regarding actions by one of the staff members of the facility. The picture showed a resident's right hand with liquid stool on it, a catheter bag on the floor with tubing attached to a stat lock (a cassette that held the urinary catheter tubing in place) and the resident's colostomy bag which had leaked. The caption to the photo was "my 13 th reason" name at the top of photo identified a name of social media account and below it was NA-A's name. The PO identified the staff member as NA-A. DON spoke with NA-A and she stated she had not made any snaps today and once she was informed of the photo evidence she confessed and told DON she had posted something to her private story, had taken it down, but not soon enough, when she realized it was inappropriate. She had a rough night prior to her shift and had influenced her decision making. NA-A had received verbal warnings in July 2021 and 2023 regarding cell phone use and social media. Education regarding facility policy on social media and electronic devices were reviewed with her and verbalized understanding. It was determined that despite the education, she lacked understanding of the seriousness of this incident as was at risk for repeat offenses, employment was terminated on 1/21/25. The photographs contained no identifying information to breach Health Insurance Portability and Accountability Ace of 1996 (HIPAA) (prohibiting the disclosure of

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| | 00968 | A. BUILDING: ______ B. WING ______ | C 01/27/2025 |

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| **VALLEY CARE AND REHAB LLC** | **600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514** |

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protected health information). The photograph was not explicit in nature. The resident did not have any verbal/nonverbal distress to the incident. All resident needs were met and it was not identified that NA-A acted in a willful manner. There was no physical confinement, punishment, or intimidation identified. DON and interdisciplinary team (IDT) determined the incident was poor judgment it would not be reported. Strict enforcement of facility cell phone policy will be implemented to protect residents, moving forward.

During an interview on 1/24/25 at 1:00 p.m. complainant (C) stated NA-A had taken a picture of a resident who sat at edge of bed after the colostomy bag had exploded. The picture showed stool on the resident hand and leg and caption on the picture was 13 Reasons why. C stated she must have had a crappy day and most likely the reason she posted it. C stated this was an invasion of privacy and a HIPAA violation.

During review of a photo attachment on 1/26/25 submitted with complaint identified a person sat with right lower arm positioned on a mattress and right hand hung over the edge with dark golden mushy yellow substance (appeared to be stool) located on the thumb, pointer and middle fingers. The person's right leg was bare from the center of the upper thigh down to the upper calf. Located on the middle top part of the right thigh was a stat lock that held the urinary catheter tubing in place with tubing attached to the catheter bag that was located on the floor folded over. The person had a colostomy bag that hung down from their right upper thigh area that contained the same stool substance located on the fingers. Top of colostomy bag was covered with material. The end of the colostomy bag clamp appeared to

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| 21980 | Continued From page 8<br>have let loose, and stool was located on the bed sheet off to the right side of the person and had ran down the side of the mattress. There was a moderate amount of stool on the floor underneath the person's right leg. Written towards the bottom of the picture was "my 13th reason" and at the top of the picture identified "2 hours ago by NA-A's name".<br><br>During an interview on 1/27/25 at 11:07 a.m. licensed practical nurse (LPN)-A stated taking photos of residents and posting them on social media would be considered very serious HIPPA violation, and an invasion of their privacy. She had told staff in report cell phone must be placed in the staff locker room and were not allowed out on the floor while they worked. The facility had posted a yellow sign a long time ago on the door by the kitchen area that indicated: No Cell Phones Allowed Beyond this Point.<br><br>During an interview on 1/27/25 at 11:17 a.m. NA-B stated staff were not allowed to have their cell phones on them while on duty and caring for residents. Residents needed to be protected and it would not be ok to take pictures and post them on social media, would be considered a HIPPA violation and most likely embarrass the resident for sure.<br><br>During an interview on 1/27/25 at 12:12 p.m. NA-A stated she had been terminated, was wrongful just from an incident with her cell phone. She had used her cell phone while she cared for a resident in his room. R1's colostomy bag had exploded, she had taken a picture of the feces, his hand, colostomy, the bed, floor, and part of his bare leg. She did not think family could have identified him in the picture there was not a picture of his face. She posted the picture of R1 | 21980 | | |

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on 1/17/25, while she was at work on a private social media site snapchat with only a handful of people on it. She removed it an hour later because she was ashamed, embarrassed, was unprofessional, and she had let her emotions get the best of her. She knew what she was doing, did it anyway, and regrets it. R1 was not asked if the picture could be taken nor was he aware it was taken, he had dementia. She said if R1 knew it had been taken and posted on social media it would have affected him negatively, he would feel embarrassed and was an invasion of his privacy. NA-A stated this would not be a HIPPA violation because there were not any specific identifiers therefore, unable to identify him. On her private social media site there were at least 15 people and at least two of them worked with her at this facility. She stated only one resident currently had a colostomy and never though about those that worked with her, they could have identified him. Staff were allowed to have had their cell phones and used them while they worked at the facility with residents. She was unable to recall any write ups in the past regarding issues with her use of cell phone at work and social media posts.

During an interview on 1/27/25 at 3:11 p.m. family member (FM) stated R1 was a very private person, made sure his colostomy and urinary catheter bags were always covered. R1 was consciousness and did not want them exposed. If a picture was taken of anyone for that matter and posted on social media even without a face would be demeaning and humiliating. R1 did not know this happened but if he did, it would have bothered him and was an invasion of his privacy.

During an interview on 1/27/25 at 3:37 p.m. DON stated 2021 NA-A had taken a picture with her cell phone along with another staff member at

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| 21980 | Continued From page 10<br>work and there was a resident behind her. She stated 2023 NA-A had taken a picture with her cell phone in a utility room by herself, held up resident's pants soiled with stool, and posted it to social media. Education was provided and included facility policy and expectations. DON stated on 1/18/27 she was made aware by a police officer (PO) on 1/17/25, NA-A had taken a picture of R1 and posted it onto social media for anyone on her account to see, unsure of how many but was too many. R1 was not aware of what happened, had a poor memory and was not interviewable. The facility had a cell phone policy in place since she became DON (2015) and staff were expected to leave their cell phones in the staff locker room while on the floor working with residents. DON stated NA-A made a poor choice in the moment, had taken a photo of a resident and posted it to social media which affects privacy and dignity. The incident was not filed with SA, the resident was not identifiable in the photo. She stated NA-A was immature, knew what she did was wrong, used poor decision making that led her to take the picture. The incident was not a willful act and was not done to hurt or embarrass R1. A reasonable person would been upset about this and asked why are you taking a picture of my colostomy. The picture was not taken to complete cares or replace the appliance and was not necessary. Any normal person would have been embarrassed, humiliated and felt it was demeaning.<br><br>During an interview on 1/27/25 at 4:07 p.m. administrator stated on 1/18/25, he was made aware of the incident when NA-A had taken a picture of a resident and posted it on social media. The incident was not reported to the SA, did not meet the reportable guidelines of the algorithm. The person in the photo was | 21980 | | |

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unidentifiable. This employee had worked at other faculties and not sure where the photo was taken, location, or which employer. He was aware of two other incidents where NA-A used her cell phone at work and posted pictures to social media. He stated staff were expected to leave their cell phones in the locker room while at work and a sign was posted by the back door for years, no cell phones beyond these doors. Immediate action was taken to ensure that there was no other staff with personal devices on the floor, provider and family notified, educated staff, and terminated staff involved. The resident was not made aware of this incident per family request.

Facility Combined Federal and State Bill of Rights last revised 2/1/17, identified each resident must be treated with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his/her quality of life. The resident has the right to be free from abuse, neglect and misappropriation of resident property, and exploitation of this subject. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

Facility policy Free from Abuse and Neglect dated 11/1/22, identified the facility will ensure that each resident has the right to be free form abuse, neglect, and corporal punishment of any type by anyone. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, and mental abuse including abuse facilitated or enabled using technology. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental and verbal abuse was defined as

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verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.

Facility policy titled Reporting of Reasonable Suspicion of a Crime/Reporting of Alleged Violations dated 2/14/24, identified:

-What should be reported: all alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property.
-Who is required to report: the facility.
-To whom: Facility administrator, Office of Health Facility Complaints (OHFC), Clay County Social Services, Law Enforcement, Attending Physician, and Resident's Representative.
-When: All alleged violations. Immediately, but not later than 2 hours. If alleged violation involves abuse or results in serious bodily injury.

Facility Social Media Policy dated 11/1/24, identified Valley Care and Rehab respects the desire of employees to use social media including but not limited to all social networking communications, electronic communications, and electronic information for personal expression. However, employees' use of social media can pose risks to the residents' confidential, proprietary and sensitive information, can harm the facility: reputation in the community, expose facility to discrimination and harassment claims, jeopardize facility compliance with business rules and laws including but not limited to the Health Insurance Portability and Accountability Act (HIPPA) and related laws and regulations protecting residents' protected health information (PHI). Electronic devices were defined as any device used for electronic communication or

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| 21980 | Continued From page 13<br>electronic information included: computers, laptops, tablets, digital cameras, video recorders, fax machines, copiers, scanners, telephone system, smart phones, cell phones, and pagers. Employees are absolutely prohibited from using social media in any way that would violate HIPPA or otherwise disclose or compromise residents' public health information (PHI). This includes but is not limited to the following: Do not use social media to post, upload, send or otherwise share or disclose a photo or video of any resident without prior written permission of the resident or the resident's authorized agent as required by applicable law. You must use Valley Care and Rehab's authorization form to obtain such prior written permission. This prohibition includes photos and videos where the resident is not easily identifiable (e.g., a photo of the resident's hand, a close up photo of any part of a resident's body, or a photo of the back of a resident in the far background of the photo). It also includes photos or video where the resident is easily identifiable, whether in the photo or video itself or through a caption. Personal use of social media is never permitted on working time.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure | 21980 | | |

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| 21980 | Continued From page 14<br>compliance is being maintained.<br><br>TIME PERIOD FOR CORRECTION: 21 DAYS | 21980 | | |