

Electronically delivered

November 6, 2020

Administrator Valley View Manor HCC 200 East Ninth Avenue Lamberton, MN 56152

RE: CCN: 245378

Cycle Start Date: August 21, 2020

Dear Administrator:

On October 13, 2020, we notified you a remedy was imposed. On November 3, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 27, 2020.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 28, 2020 did not go into effect. (42 CFR 488.417 (b))

As we notified you in our letter of September 1, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 22, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies. Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fish Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: kamala.fiske-downing@state.mn.us



Electronically delivered

November 6, 2020

Administrator Valley View Manor HCC 200 East Ninth Avenue Lamberton, MN 56152

Re: Reinspection Results

Event ID: GT4K12

#### Dear Administrator:

On November 3, 2020 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 September 22, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kamala Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us



Electronically delivered

October 13, 2020

Administrator Valley View Manor HCC 200 East Ninth Avenue Lamberton, MN 56152

RE: CCN: 245378

Cycle Start Date: September 22, 2020

Dear Administrator:

On September 1, 2020, we informed you that we may impose enforcement remedies.

On September 22, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

#### REMOVAL OF IMMEDIATE JEOPARDY

On September 16, 2020, the situation of immediate jeopardy to potential health and safety cited at scope and severity of K for tag F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

On September 17, 2020, the situation of immediate jeopardy to potential health and safety cited at scope and severity of J for tag F686 was removed. However, continued non-compliance remains at the lower scope and severity of G.

#### **REMEDIES**

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal

regulations at 42 CFR § 488.417(a), effective October 28, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 28, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

#### SUBSTANDARD QUALITY OF CARE (SQC) (Delete if not SQC and this note)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Valley View Manor Hcc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 22, 2020. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

#### 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

#### DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

#### 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 21, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

#### Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132

> Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at <a href="mailto:Tamika.Brown@cms.hhs.gov">Tamika.Brown@cms.hhs.gov</a>.

#### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04-8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04-8.html</a>

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



Electronically delivered October 13, 2020

Administrator Valley View Manor HCC 200 East Ninth Avenue Lamberton, MN 56152

Re: State Nursing Home Licensing Orders

Event ID: GT4K11

#### Dear Administrator:

The above facility was surveyed on September 14, 2020 through September 22, 2020 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 <u>only a suggestion</u> 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program

Kamala Fishe Downing

Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

PRINTED: 10/30/2020 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	245378 PROVIDER OR SUPPLIER VIEW MANOR HCC		CTREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152	09/22/20 <u>20</u>
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F 000	On 9/14/20 through 9/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.  The following complaints were found to be SUBSTANTIATED: H5378022C and H5378023C with deficiencies cited at F600, F609, F610 and F686.  The survey resulted in an Immediate Jeopardy (IJ) at F600, when the facility failed to ensure 1 of 1 resident (R1) was free from abuse after allegations of sexual abuse were identified. The facility also failed to protect R1 from potential further abuse by advising the alleged perpetrator, licensed practical nurse (LPN)-A of her identity. This caused actual psychosocial harm to R1 as LPN-A was not immediately restricted from work pending an investigation and continued to provide care to 22 of other 44 residents in the facility for 2 additional days. The IJ began on 9/4/20, and the immediacy was removed on 9/16/20 at 4:45 p.m  The survey resulted in another Immediate Jeopardy (IJ) at F686, when the facility failed to appropriately assess, monitor, and notify the physician for 1 of 1 resident (R2) with new onset pressure ulcer leading to hospitalization, wound debridement, and admission to hospice services. The IJ began on 8/23/20, when staff identified a new onset pressure ulcer. This caused actual harm to R1.The immediacy was removed on 9/17/20 at 3:45 p.m  The above findings constituted substandard	F 000		
L AROBATOR)	/ DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

**Electronically Signed** 10/21/2020 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 600 SS=K	conducted from 9/1  The facility's plan or as your allegation of Department's accept and a page of the CMS-21 submission of the Experiment's accept of the CMS-22 submission of the Experiment o	an extended survey was 6/20 through 9/21/20.  If correction (POC) will serve of compliance upon the otance.  In rolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as oliance.  In acceptable electronic POC, an uir facility may be conducted to untial compliance with the en attained in accordance with and Neglect 1)  In a superior of resident property, defined in this subpart. This imited to freedom from the interior of the interio	F 600			10/27/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	· ·	X3) DATE : COMPL	
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	PROVIDER OR SUPPLIER	IU AVIIII		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE		
VALLEY	VIEW MANOR HCC			LAMBERTON, MN 56152		
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F 600	review, the facility fa (R1) was free from sexual abuse were failed to protect R1 by advising the alleg practical nurse (LPI This caused actual LPN-A was not immeding an investig care to 22 of 44 resulting and investigations of Agency and implement to keep R1 and other abuse. The facility at the IJ on 9/15/20 at removed on 9/16/20 non-compliance reruseverity G, actual his jeopardy.  Findings include:  Review of the 9/8/20 Agency identified the report identifying the was notified on 9/4/by licensed practical advised staff she has room. R1 alleged L1 had come into R1's hours and picked up floor. LPN-A advised under the nasal care was from the condetermine from the	ion, interview and document alled to ensure 1 of 1 resident abuse after allegations of identified. The facility also from potential further abuse ged perpetrator, licensed N)-A of the resident's identity. psychosocial harm to R1 as rediately restricted from work ation and continued to provide idents in the facility for 2  1/20, when the facility failed to f abuse, report to the State residents and procedures are residents safe from further administrator was notified of 1:00 p.m The IJ was	F 600	R1 had a risk management incident created 9-8-20. The MD was notified 9-9-20. the Police were called on 9-15-20. Her vulnerable adult care p was reviewed and updated and her preferences were reviewed and incluand updated. Social Services met w on 9-8-20, 9-9-20 and 9-10-20. MD contacted to review resident request external foley catheter. R1 was discharged on 9-22-20.  On 9-15-20, All residents were interviewed and verbalized they feel living at the facility. All residents vulnerable adult care plan and preferences were reviewed and updates a needed. For new admissions the Social Service director will ask the residents preference regarding male female caregivers and will review the care plan quarterly and as needed. RN-A was in-serviced on abuse investigation and reporting incidents accuracy. LPN-A was terminated on 9-15-20. The Administrator and DON in-serviced on abuse reporting, how make a report in the SA portal, keepi resident complaints anonymous and suspension of employee/s upon suspof an allegation. The Administrator, Director of Nursing, ADON and Social Service Director all have access to the reporting platform and will be respons for reporting allegations of abuse 24/ Investigations with allegations of abuse will begin immediately. An on-call schedule was implemented on 9-28-who to report to with any allegation of abuse will begin immediately.	d on olan uded vith R1 was for safe ated e or eir with n were to ing picion al he nsible /7. use 20 on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	09/2	2/2020
VALLEY	VIEW MANOR HCC			AMBERTON, MN 56152		
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F 600	R1 was laying in be along her bottom". was going to check Action taken by fac advised LPN-A not there was another swas suspended per investigation.  Review of the facilit began on 9/8/20 pe R1 advised (RN-A) does not want a major time) stated he op.m. Over a week at the nurse aide on dwas on break. R1 hon. LPN-A stated he R1 what she needed water. LPN-A went return, noted a pud LPN-A gave R1 her out where it came for slightly to check he was trying to figure from. LPN-A patted on her face". LPN-A down and cleaned identified R1 freque and voids in her becontact". We (facilit caregivers. If he (LI medication or atten male nurses will take them into the room's suspension on 9/8/20.	d, and "moved his hands LPN-A had not advised R1 he her for alleged incontinence. ility was identified as the DON to go into R1's room unless staff person present. LPN-A report on 9/7/20 pending an report on 9/4/20 at 10:10 p.m. she alle care giver. LPN-A (no date ame to work on 9/4/20 at 8:00 ago (unsure of date and time), uty that night of the incident, and reportedly put her call light answered it. LPN-A asked d. R1 stated she wanted cold to retrieve the water and upon dle or urine on the floor. The water and was trying to figure rom. He lifted R1's cover red. LPN-A advised R1 he out where the urine came the bed. R1 had a "funny look A immediately put the covers up the floor. The notes ently refused to be changed d. "there was no inappropriate y staff) will care plan "no male PN-A) needs to give d to medical tx [treatment], are another female staff with '. LPN-A was notified of his	F 600	abuse and posted at each nurses by the phone. This schedule will be updated weekly.  Full time facility staff were in-serving 9-15-20 and 9-16-20 on the facility for reporting abuse with the emphase reporting incidents immediately. As staff meeting will be held on 10-26 review the facility abuse policy with emphasis on when Law Enforcement MD, Primary Provider, Ombudsmas guardian will be notified.  Resident Care Audits along with all reporting, timeliness, resident preficand risk management incidents with 2x week for 2 weeks, weekly x3 with the monthly x 1 year. Audits will be to QAPI by the Administrator mont months for oversight and to ensure compliance.  Social Services and/or designee were sponsible for compliance.	deed on a policy pasis of an All policy pasis of an All policy pasis of an All policy pasis of an and policy pasis of an and policy pasis	
		n notes identified LPN-A also finished cleaning up R1's				

AND BLAN OF CORRECTION INDENTIFICATION NUMBER:		` '	` '		ATE SURVEY OMPLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	left the room. On 9/interviewed by the sidentified R1 was or 9/4/20 and saw LPN NA-A and NA-B not since she felt uncor when the incident of occurred, but it was entered her room donasal cannula and LPN-A it was wet fire to get new tubing. Fiside with her back for LPN-A returned, her brief. R1 declared sto summon LPN-A other staff has ever in that manner. R1 safe. All staff were Both NA-A and NA-NA-B stated on the outside smoking, cas shaking. NA-B asked replied "Not really." In ervous". Both NA's reported she had wher brief by sticking brief without telling wet. After talking to advised LPN-A was Other staff were interviewed for safe concerns with staff. notified on 9/8/20 a identified as being rindicated in the reported she had in the reported she in interviewed for safe concerns with staff.	ge 4 A were both "joking" when he 8/20 at 8:35 a.m., R1 was SW. Notes of that interview utside smoking the evening of N-A report to work. R1 advised to let him come into her room infortable. R1 was unclear on a finappropriate contact had before 9/4/20. LPN-A had uring the night, picked up her said it was wet. R1 advised om condensation. LPN-A left R1 stated she was lying on her acing the doorway. When touched her bottom inside her she had not used her call light that night. R1 declared no checked her for incontinence reported to the SW she felt good to her except LPN-A. B were interviewed on 9/8/20. night of 9/4/20, R1 was ame inside and was visibly ed if she was ok to which R1 Seeing [LPN-A] makes me is took R1 to her room. R1 oken up to LPN-A checking his finger in the back of her her. R1 denied she had been RN-A, NA-A and NA-B were in the stook R1 to her room. R1 oken up to LPN-A checking his finger in the back of her her. R1 denied she had been RN-A, NA-A and NA-B were in the back of her her. R1 denied she had been RN-A, NA-A and NA-B were in the back of her her. R1 denied she had been RN-A, NA-A and NA-B were in the back of her her. R1 denied she had been RN-A, NA-A and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were in the back of her her. R1 denied she had been RN-A, NA-B and NA-B were she had been RN-A, NA-B and NA-B were she had been	F 600			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	CTION (X3) DATE SU COMPLE	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
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F 600	he failed at commulidentified were male accompanied by a request. Before retube inserviced on the residents what he is was to have one-or RN-A was to be insimportance of gettin reporting timely. The corrective actions, management had in the suspicion of a cenforcement within There was also no identified it failed to procedures by imminvestigation and suppon notification of no mention of apprand or the residents care physician.  R1's 8/17/20, admissional conditions and requifor toileting.  R1's 8/18/20, progradmitted to the facis services related to	d intent of abuse. We believed nication". Corrective action e staff were to be female staff per resident urning to work, LPN-A would e importance of explaining to s doing before hand. LPN-A none supervision for 1 week. erviced on 9/14/20 on the ng all the facts first hand and e facility was to monitor its. There was no mention facility dentified they failed to report trime to the SA and law 2 hours of the allegation. mention the facility had	F 600			
	weakness, chronic (COPD).  Interview on 9/14/2	back pain, muscle obstructive pulmonary disease 0, with LPN-A identified the urred about a week ago to his				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	` '	E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152	09/2	0 2 <b>2/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	of the incident. R1 happroximately 3:00 tubing and it was lat the end of her bed from to get R1 new proceeded to hook laying in bed on her from her door. R1 hadvised her he was underneath her O2 falling into the liquid to clean it up. R1 was that point". LPN-A pincontinence pad. L not advised R1 wha brief. LPN-A asked to help her clean up stated he made a "j he left the room. R1 known about not restaff members. LPN have leaked urine bethe area directly bel of the bed, was dry. cares. In hindsight, clear" during cares. (RN)-A had advised R1's room at any tirhad touched R1 inat to call the DON and The DON called bar was told to keep his another staff members was suspended investigation. He ha 9/6/20. LPN-A had das he was turning ir	ge 6 was charge nurse on the night had put her call light on at a.m R1 had lost her oxygen ying on the floor in a puddle at by R1's feet. LPN-A left the O2 tubing. LPN-A then up R1's new tubing. R1 was a side, facing the wall, away ad a fluffy blanket. LPN-A cleaning up the liquid found tubing. R1's blanket kept on the floor as he was trying as "uncomfortable with me at proceeded to touch R1's PN-A acknowledged he had at he was going to check her R1 if she wanted another staff or, but she refused. LPN-A then oke" to which R1 laughed and had never made concerns beliving assistance from male II-A was unsure how R1 could by the foot of her bed, when ow her bottom, in the middle R1 had been known to refuse he should have been "more On 9/4/20, registered nurse him he was not to go into me. RN-A advised LPN-A he ppropriately. RN-A was going alert her to R1's allegations. On 9/8/20 pending an alert her to R1's allegations. On 9/8/20 pending an alert her to R1's allegations. On 9/8/20 pending an alert her to R1's on 9/14/20 in his resignation effective work his upcoming 3	F 600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
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F 600	LPN-A was resigning Review of LPN-A's ataff schedules and LPN-A was schedul 8/27/20, 8/31/20, 9/9/6/20 LPN-A's timon: 1) 8/27/20, beginning 2) 8/31/20, beginning 3) 9/3/20, beginning 4) 9/4/20, beginning 5) 9/5/20, beginning 5) 9/5/20, beginning a.m., 6) 9/6/20 beginning a.m., 6) 9/6/20 beginning 7:09 a.m.  Review of LPN-A's performance review complaints were ide 9/4/20. There was rany disciplinary active education following The review identifier both units and prefet LPN-A was identifier residents. LPN-A was identifier residents. LPN-A was identified he need only, before you do check performed 6/had no criminal hist 11/18/19. There was check identified in hand problem resolur regard to R3's compagina, it was identified in hand problem resolur regard to R3's compagina, it was identified in hand problem resolur regard to R3's compagina, it was identified to the compagina and problem resolur regard to R3's compagina, it was identified to the compagina and problem resolur regard to R3's compagina, it was identified to the compagina and problem resolur regard to R3's compagina, it was identified to the compagina and problem resolur regard to R3's compagina, it was identified to the compagina and problem resolur regard to R3's compagina, it was identified to the compagina and problem resolur regard to R3's compagina and problem resolur regard	ge 7 9/17/20 through 9/19/20. g over the allegations.  August and September, 2020, time clock entries identified ed to work overnight shifts on 3/20, 9/4/20, 9/5/20, and recard identified he worked ag at 6:00 p.m. until 6:46 a.m. ag at 9:58 p.m. until 6:51 a.m. at 10:01 p.m. until 6:40 a.m. at 8:03 p.m. until 6:46 a.m. at 6:02 p.m. through 6:28 at 5:58 p.m. and finishing at employee file identified a redated 9/14/20. 3 resident entified on 5/5/20, 6/22/20, and no indication LPN-A received ons or additional training or those resident complaints. at LPN-A was flexible, worked erred working his night shift. It dhaving conflicts with some as to watch his tone as he had ements without realizing it. It eleded to "explain what you are to it." LPN-A had a background 3/20, which identified LPN-A ory reported. LPN-A was hired as no previous background its file. LPN-A had concern tion coaching's in his file. With claint of LPN-A looking at her fied by the facility LPN-A had only its all in your head and	F 600			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE : COMPI	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	09/2	C <b>22/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	he made her "skin of other staff weren't a "creepy voice I'm work. No disciplinar LPN-A's file.  Interview on 9/14/20 identified she was in 9/4/20 by R1. R1 has she had seen LPN-at approximately 8:0 noted R1 was afraid R1 stated "I don't with me. R1 elabora uncomfortable the lacame into her room date) and started "pwears an incontiner was touching her in know what to say to advised she was shold anyone about the she was afraid. R1 into any further deta NA-A and NA-B left immediately. RN-A spoke to her about room and looked to allegations R1 had witnessed telling LF R1's room. R1 had male staff. There we floor and R1 had no member.  Interview on 9/14/20.	"R3 reported to management crawl" and was rude when around. He told her in a back" when he returned to y actions were included in  O with nursing assistant (NA)-A made aware of the incident on ad reported to NA-A and NA-B A report for his shift that day on p.m R1 was outside. Staff to come in and was shaking. ant that [expletive] working atted LPN-A had made her feel ast time he worked. LPN-A during the incident (unknown toking" at her bottom. R1 nocked and scared. R1 had not not be priced and scared. R1 had not not incident before 9/4/20, and began to cry and would not go all with NA-A or NA-B. Both R1's room and advised RN-A went into R1's room and the incident. RN-A exited the be visibly upset by the advised her of. RN-A was PN-A he was not to go into never had any concerns with as another male staff on the or concerns with that male staff	F 600			
		smoker and was outside the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	DID AN OF CORRECTION AND INCREMENTATION NUMBERS		E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	NA-B had noticed F doorbell to come bashaking and visibly NA-A and NA-B promatter was. She was proceeded to tell the her room the other advised LPN-A was was wet. He stuck it touched her inapproherself and requires herself to bed etc. Sishe was first admitt discharge soon. NA and advise her of the soon as possible. Risoon as she was done RN-A finished her mispeak with R1 in he of R1's room, she with working on that wing to go into R1's room LPN-A came to working on the working. R1 if LPN-A was comin Cobservation and into p.m., with R1 identifies hifts. R1 goes to be incident which R1 reworked but was unsupported by the previous with t	at day for his shift. NA-A and at was outside and rang the ack into the facility. R1 was upset. "She was petrified". ceeded to ask R1 what the as reluctant to say. R1 e staff LPN-A had come into night when he worked. R1 checking her to see if she his fingers in her brief and opriately. R1 takes care of a no assistance to toilet or put the only needed help when ed. R1 was expected to and NA-B left to find RN-A he need to speak with R1 as and NA-Was giving meds, and as one, she would speak with R1. In edication pass and went to ar room. When RN-A came out went to LPN-A who was g and advised him he was not an Today on 9/14/20, when k, R1 saw him come in. She kept watching the door to see	F 600			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLIANCE (X3) DATE S		E SURVEY PLETED			
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		ETREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	2 <mark>2/2020</mark>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	up startled when sh room. R1 wore O2 a off. Her tubing was of her bed. LPN-A pR1 and she advised it was wet on the flot LPN-A then grabbed and came back with advised her the spot feet "looked like per condensation from oxygen. R1 stated she brief. LPN-A showed up the liquid on the dirty. R1 slept with the times and would lay away from the door sudden, R1 felt her was poking his fingulated she was" terranything. He would stop. She heard click what they were compounded like a pen saw any flash or light LPN-A had penetratives on my butt che stated she had never before. LPN-A was toilets herself and hattempt to check he identified she was "the nerve to talk." Lened to be changed LPN-A replied to he room. R1 stated LP touching her buttooms.	ge 10  e was sound asleep but woke e realized LPN-A was in her at night. Occasionally this falls laying on the floor at the foot bicked up the tubing, gave it to d him it was wet. LPN-A stated for where her tubing had been. In the wet tubing, left the room, in new O2 tubing. LPN-A at of liquid on the floor at her e." R1 advised him that was her O2 tubing with humidified she had not felt wet in her d her the rag after he wiped floor and showed her it was the over-bed lights on at all on her left side with her back facing the wall. All of a covers being lifted and LPN-A ters on her [expletive]. R1 rified." LPN-A had not said start feeling her bottom, then taking noises but was unsure hing from. She thought it light nurses use, but never hat of any kind. R1 denied ted her in any way. His finger ck going up and down. R1 ter been touched like that not touching her brief. R1 ad no reason for LPN-A to the brief for wetness. R1 so scared" and "hadn't had PN-A finally said, "Do you d?" R1 was able to say "No".  r "Alright then" and left her N-A was very intentionally ks and was not in any way on and ever touched her that way and the process of the process.  Take the realized but work to denote the process of the process to denote the process t	F 600			

AND DUAN OF CODDECTION IN IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	2 <mark>2/2020</mark>
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F 600	male staff at any he wet spot on the floor directly below that night and again saw LPN-A arrive for was coming back to saw LPN-A today at shaking, and got a stomach with nause around LPN-A. "I care can't". R1 was going independently with interview of R1 identerview of R1 identerview.  Interview on 9/14/20 identified she was not sexual abuse from RN-A stated NA-A advised her they we R1 was shaking. R1 and the staff wanter requested RN-A speand NA-B she would passed her medication pass, and RN-A had never me occasional staff me she was working in reported she "just de [LPN-A] gives me the was about 2:00 a.m. her O2 would come occasionally during the same content of the spean	er had any concerns with any ealth facility. R1 elaborated the r was by her feet, not on the her bottom. R1 was scared a today on 9/14/20, when she or work. R1 was afraid LPN-A owork. R1 stated when she rrive for work, she started 'creepy" feeling in her ea. R1 does not feel safe an talk! Others [residents] g home soon and walked cares. Observations during stified was visibly shaken was ressed anger throughout the D at 6:06 p.m. with RN-A nade aware of the allegation m R1 by LPN-A on 9/4/20. and NA-B came up to her and ere walking R1 to her room. I found out LPN-A was on duty d to make sure it was ok, and eak to R1. RN-A advised NA-A d speak to R1 as soon as she tions. NA-A and NA-B followed a almost finished with and would be there shortly. Et R1 before as she is an mber. On that day of 9/4/20, the back half of the facility. R1 idn't like way things went. He he creeps". She couldn't recall nt occurred, but identified it in or 3:00 a.m. R1 reported	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	( )		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIED VALLEY VIEW MANOR HCC	<b>245378</b>	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Without notice, Lifther covers. That in took his finger and RN-A asked her wabout him. R1 sail bathroom door to being wet. R1 der just left. RN-A assforwarded. R1 als molested as a chi RN-A had not included as R1 seemed en molestation. RN-A assessment or stated she called instruction on how advised RN-A to was nay further in allegations. The Eto her knowledge, the facility after shad not talked to LPN-A. RN-A had report to the SA, in crime to the police the DON and doe was an occasional worked for a while to work that day, is reporting, advised she had questions physically examining of sexual abuse her reverse and resident in the sexual abuse her reverse and resident in the sexual abuse her reverse reverse she sexual abuse her reverse rever	rised R1 the floor was wet. PN-A put his hand underneath made R1 "creep out". LPN-A d was "touching inside her brief. What she would like her to do d he wiped a spot by the wards edge of bed. R1 denied nied penetration, and stated he sured R1 her concerns would be to advised RN-A she had been lid and it felt "just like that". Unded that in her written report inbarrassed about her past in A had not performed an arted an investigation. RN-A the DON right away for to proceed. The DON had write a report and see if there formation R1 had on the DON had not suspended LPN-A. The DON had called back to be had spoken with her, but she RN-A. The DON spoke to never been educated on filing a nor reporting a suspicion of a see. RN-A looks for direction from a swhat she is told. Since RN-A il staff person, she had not be prior to 9/4/20. Upon arriving she was handed the policy on to read through it and ask if see. RN-A had made no attempt to be RN-A had made no attempt to e R1 on 9/4/20 after allegations	F 600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152	09/2	2 <mark>2/2020</mark>
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F 600	was unable to give a her room. R1 was un her room. R1 was un her room. R1's nasa was on the floor. LF R1 advised she felt (from humidified ox her bedspread and her "butt". LPN-A hawas doing. She required in the facility on 9/4, of the incident. On swork and saw RN-A immediately went to advised her this was review of the staffin 9/4/20, it was identified shifts were 9/3/20 anot have seen LPN-9/3/20, as she would incident was reported shift time-frame he SW agreed the inciditively occurred on 8 of the investigation, had plans to submit that day. The SW controborate there we LPN-A advised her indeed at the end of directly below where "definitely upset above ensure LPN-A had in was visibly upset, not also in the submit that was visibly upset, not also in the submit that day. The SW controborate there we LPN-A had in was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day. The SW controborate there we LPN-A had in was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset, not also in the submit that day was visibly upset.	touching her one time but a date. LPN-A had come into insure why LPN-A had entered al cannula had come off and PN-A picked it and it was wet. it was wet from condensation ygen). LPN-A had picked up started moving his hand along ad not advised R1 what he uested he not enter her room.  The review on 9/15/20 at 9:43 dentified the DON never came /20, after being made aware 9/8/20, the SW arrived for a reportable incident. In g schedule leading up to fied LPN-A's last scheduled and 8/31/20. LPN-A. R1 would -A arrive for that shift on d have been in bed, and the ed to occur the last weekend worked before 9/4/20. The dent would have most have /31/20. The SW was in charge which was still ongoing. She the 5 day report to the SA oncluded she couldn't prove occur. The SW could not as actual urine on the floor. the location of the urine was fithe bed by R1's feet and not a her bottom was. R1 was out it". The facility wanted to not worked with R1 again. R1 ot crying, but anxious SW recalled her interview with R1 are allocations.	F 600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	should have told he reviewing the location floor, the SW agree urine could have de rather than directly be the middle of the beaway. The SW identification allowed to make repethe DON and admir wearing a brief wou urine on the floor are bedding being wet. The SW about tooks was being would be inconsisted pulled away from he also agreed R1 had and there was no not incontinence. The Shave immediately such aring the allegation fracility procedures or the DON could such the staff were allowed suspicions of a crimical literature. The Shave immediately such aring the allegation fracility procedures or the DON could such the staff were allowed suspicions of a crimical literature on 9/15/20 practitioner (NP)-A in R1's allegation of secalled her, only to a (MD) number last we covering nights and the facility on 9/8/20 the allegations at the expect the facility for	what went wrong was he r what he was doing". In on of the fluid found on the d, there was no way R1's eposited at the foot of her bed, below her bottom located in ed, approximately over 2 feet tiffied the only staff that were ports the to SA were herself, histrator. She also agreed R1 ld have limited deposits of and would have saturated R1's ed R1 made no mention of her R1 also claimed LPN-A had ef, but was touching her agreed, R1's accounts her stroked by LPN-A's fingers ent if her underwear were er body to feel a brief. The SW I been independent to toilet eed to physically check her for SW agreed the DON should uspended LPN-A upon on and reported to the SA. indicated only the SW, admin ubmit a report to the SA. No owed to submit reports of	F 600			

-	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  LAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245378	B. WING	MI EDGEM	C
	PROVIDER OR SUPPLIER VIEW MANOR HCC	243376	b. Willa	STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152	09/22/202 <u>0</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLÉTION
F 600	any allegation of all was made aware of surrounding the all facility keep the resistaff until an invest improved in the able could walk indeper was fully cognitive, next few days.  Interview on 9/15/2 identified she had approximately 10:0 and advised R1 was LPN-A. The DON sinformation and shadvised RN-A to fir complaint and to capproximately 15 in facility. LPN-A answasked him if he "diwanted to file a cordenied any wrongo of the incident in quanted to file a cordenied any wr	ouse or neglect is made. NP-A f the interviews and events egations. NP-A expected the sident safe and suspend any igation was completed. R1 had lity to care for herself and idently, toilet independently, and was set to go home in the 0 at 10:53 a.m., with the DON received a call on 9/4/20 at 0 p.m., RN-A had called her inted to file a complaint against stated RN-A offered no other e had not asked. The DON and out what prompted such a	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	. ,	E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	other residents at riretaliation. The DOI investigation immediate the facility until 9/8/2 alerted to RN-A's wisuspended pending. The DON agreed he prevent abuse and put all residents at rill Interview on 9/15/20 identified he had not incident until approxiby the facility R1 regraybe she had not upset. MD had not hunaware LPN-A was the DON, nor that Lisuspended immediately peallegation. The MD keep R1 and all oth retaliation or potentiagreed LPN-A shou policies implemente have been immediated. Interview on 9/15/20 identified she had not suspicion of a crime. The SW had reported board of Nursing.  Review of the 9/4/20 Management policy responsibility of emphysicians, family mediated to the suspicions, family mediated to the suspicion of a crime. The SW had reported board of Nursing.	ding LPN-A placed R1 and sk for further abuse or N failed to begin an liately and had not returned to 20. At that time, she was ritten report. LPN-A was the facilities investigation. For resolution and actions to failing to follow facility policy sisk.  O at 12:27 p.m. with the MD to been made aware of the kimately 9/8/20. He was told borted LPN-A felt her bottom, liked that and was found very known "much more". MD was a notified of R1's identity by PN-A had not been ately, or that no investigation arformed upon identifying the agreed the facility failed to get 44 residents safe from all further abuse. He also lid have been suspended, and an investigation should	F 600			

AND FLAN OF CORRECTION IDENTIFICATION NOMBER. A. BUILDING	ETED.
C 09/22/ NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW MANOR HCC  STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152	2/20 <u>20</u>
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
All allegations were to be reported and thoroughly investigated. All reports made were to be made without fear or retaliation from facility or its staff. Reports were to be given to the DON. In her absence, reports were to be made the the charge nurse. Staff members shall not knowingly fail to report an incident or offense, screen reports, or withhold information from reporting agencies. If incidents were discovered after hours (8:00 a.m. to 5:00 p.m.), the admin or DON must be called at home and informed of the incident. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Employees accused of abuse were to be suspended immediately pending the outcome of the investigation. For reports of physical or sexual abuse, a thorough examination was to be performed by licensed nurses. An immediate investigation was to be made and a copy provided to the administrator.  Review of the 9/4/20, Abuse Investigations policy identified all reports of abuse were to be promptly reported and thoroughly investigated by the facility immediately but no later than 2 h ris after the allegation. The Ombudsman was to be notified and offered to participate in the investigation. The Ombudsman was to be notified of results of the investigation. Employees were to be suspended immediately. The administrator was to provide a written report of the results to the SA, local police, medical director and others within 5 days of the incident. There was no mention suspicions of a crime were to be reported immediately but not later than 2 hours. There was also no mention investigations were to be propried immediately but not later than 2 hours. There was also no mention investigation immediately but lotoin investigations were to begin immediately but	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ENDI	245378	B. WING	// EDCEMI	09/	C <b>22</b> / <b>202<u>0</u></b>
	PROVIDER OR SUPPLIER  VIEW MANOR HCC	10 ACILI	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE		
				AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	Continued From pa	ige 18	F 600			
F 609 SS=D	verified the facility tappropriately traine policies for identifyiresidents, and implication with management at the ensure reports to appropriate entities implemented to kee investigations begund Reporting of Allege CFR(s): 483.12(c)( §483.12(c) In response of the exploitation must: §483.12(c)(1) Ensure involving abuse, nemistreatment, inclusively and management at cause the allegement of the events that cause the allegement of the administrator of officials (including the events that cause and do not rethe administrator of officials (including the events that cause the events that cause and the events that cause and do not rethe administrator of officials (including the events that cause and the events that cause the events that cause the events that cause and the events that cause and the events that cause the events that cause and the events that cause the events that cause and the events that cause the events tha	d Violations 1)(4)  onse to allegations of abuse, in, or mistreatment, the facility are that all alleged violations eglect, exploitation or ding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in that law through established	F 609			10/27/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	COM	SURVEY PLETED
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NAME OF F		245376		TREET ADDRESS SITY STATE ZID SODE	09/2	22/202 <u>0</u>
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE	_   \	
VALLEY	VIEW MANOR HCC			AMBERTON, MN 56152		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	VI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 609	Continued From pa	.ge 19	F 609			
	Survey Agency, with incident, and if the appropriate correct This REQUIREMEN by: Based on observative review, the facility for the survey of t	ate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken.  NT is not met as evidenced tion, interview and document ailed to ensure an allegation of		R1 had a risk management incider created 9-8-20. The MD was notified	ed on	
		reported immediately but no for 1 of 1 resident (R1) to the ocal police.		9-9-20. the Police were called on 9 Her vulnerable adult care plan was reviewed and updated and her preferences were reviewed and inc and updated. Social Services met v	luded	
	Review of the 9/8/2 Agency identified the report identifying the was notified on 9/4/	0 report filed to the State ne social worker (SW) filed a e director of nursing (DON) /20 of inappropriate touching al nurse (LPN)-A to R1. R1		on 9-8-20, 9-9-20 and 9-10-20. MD contacted to review resident requesexternal foley catheter. R1 was discharged on 9-22-20.  All residents vulnerable adult care	was st for	
	advised staff she har room. R1 alleged L had come into R1's	ad not wanted LPN-A in her PN-A, at an unknown date, room during the overnight		and preferences were reviewed an updated as needed.		
	floor. LPN-A advise under the nasal car was from the conde oxygen (O2). LPN-A R1 was laying in be	p R1's nasal cannula off the d R1 there was fluid directly nnula. R1 advised LPN-A it ensation from humidified A picked up R1's bedding as ed, and "moved his hands		The Administrator and DON were in-serviced on abuse reporting, how make a report in the SA portal, kee resident complaints anonymous an suspension of employee/s upon su of an allegation. The Administrator	ping d spicion	
	was going to check Action taken by fac advised LPN-A not there was another s was suspended per investigation. There	LPN-A had not advised R1 he her for alleged incontinence. ility was identified as the DON to go into R1's room unless staff person present. LPN-A report on 9/8/20 pending an e was no mention the facility legation to local police.		Director of Nursing, ADON and Soc Service Director all have access to reporting platform and will be respond for reporting allegations of abuse 2 Investigations with allegations of abuse will begin immediately. An on-call schedule was implement 9-28-20 on who to report to with An	the onsible 4/7. ouse ted on	
	Review of the facilit	ty's investigation notes, which		Allegation of abuse and posted at a nurses station by the phone. This schedule will be updated weekly.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
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m/	<u> </u>	245378	B. WING	<del>//                                    </del>	09/2	22/2020
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC			00 EAST NINTH AVENUE		
			_ <u> </u>	AMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 609	does not want a may or time) stated he cop.m. Over a week at the nurse aide on downs on break. R1 hon. LPN-A stated hon. LPN-A stated hon. LPN-A went return, noted a pud LPN-A gave R1 her out where it came for slightly to check he was trying to figure from. LPN-A patted on her face". LPN-A down and cleaned identified R1 freque and voids in her becontact". We (faciliticaregivers. If he (LI medication or attenmale nurses will take them into the room's suspension on 9/8/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	on 9/4/20 at 10:10 p.m. she ale care giver. LPN-A (no date ame to work on 9/4/20 at 8:00 ago (unsure of date and time), uty that night of the incident, and reportedly put her call light answered it. LPN-A asked at. R1 stated she wanted cold to retrieve the water and upon all or urine on the floor. It water and was trying to figure from. He lifted R1's cover are bed. LPN-A advised R1 he out where the urine came the bed. R1 had a "funny look a immediately put the covers up the floor. The notes and the remaining the plan "no male PN-A) needs to give do medical tx [treatment], are another female staff with 't. LPN-A was notified of his	F 609	Full time facility staff were in-service 9-15-20 and 9-16-20 on the facility for reporting abuse with the emphase reporting incidents immediately. A Staff meeting will be held on 10-26 review the facility abuse policy with emphasis on when Law Enforcemed MD, Primary Provider, Ombudsmas guardian will be notified. New employees will receive abuse education during their orientation pand will continue annually.  Audits on reporting abuse allegation timely, facility notification posting on-call staff for reporting will begin week for 2 weeks, weekly x3 week monthly x1 year. Audits will be take QAPI by Administrator monthly x3 for oversight and to ensure complication positions. Responsible Party: Director of Nur Designee	policy asis of an All 6-20 to a ent, an and ent of 2x as then en to months ance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	. ,	SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		ETREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
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F 609	to get new tubing. Find side with her back for LPN-A returned, her brief. R1 declared in the staff has ever in that manner. R1 in safe. All staff were good both NA-A and NA-NA-B stated on the outside smoking, cashaking. NA-B asked replied "Not really. Some reported in the staff were good in the outside smoking, cashaking. NA-B asked replied "Not really. Some reported in the staff in the staff were into advised LPN-A was other staff were into the staff were into the facility identified as being reduced in the reported in the staff. In the facility identified not abusive, nor had be failed at communicated in the reported in the residents what he is was to have one-on RN-A was to be inserting importance of getting in the staff.	om condensation. LPN-A left at stated she was lying on her acing the doorway. When touched her bottom inside her he had not used her call light hat night. R1 declared no checked her for incontinence reported to the SW she felt good to her except LPN-A. B were interviewed on 9/8/20. night of 9/4/20, R1 was ame inside and was visibly at if she was ok to which R1 Seeing [LPN-A] makes me took R1 to her room. R1 oken up to LPN-A checking his finger in the back of her ner. R1 denied she had been RN-A, NA-A and NA-B were not allowed in R1's room. erviewed, but had no cident. Other residents were ty and had no issues or The Ombudsman was notified on 9/9/20. It was ort, after review of interviews, "it was our belief LPN-A was definitent of abuse. We believed nication". Corrective action	F 609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	` '	E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	0 2 <b>2</b> /20 <u>20</u>
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F 609	management had ic the suspicion of a c enforcement within R1's 8/17/20, admis (MDS) assessment cognitive and requir for toileting. R1's 8/18/20, progradmitted to the facil services related to had pans to return hidiagnoses were low weakness, chronic (COPD).  Interview on 9/14/20 above incident occuknowledge. LPN-A of the incident. R1 happroximately 3:00 tubing and it was latthe end of her bed be room to get R1 new proceeded to hook laying in bed on her from her door. R1 hadvised her he was underneath her O2 falling into the liquic to clean it up. R1 was that point". LPN-A pincontinence pad. L not advised R1 what brief. LPN-A asked to help her clean up	There was no mention facility dentified they failed to report rime to the SA and law 2 hours of the allegation.  Ssion Minimum Data Set identified she was fully red extensive assist of 1 staff these should be shown as the standard of the	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING		. ,	(3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	245378	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	22/20 <u>20</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	known about not red staff members. LPN have leaked urine be the area directly bel of the bed, was dry. cares. In hindsight, clear" during cares. (RN)-A had advised R1's room at any tin had touched R1 ina to call the DON and The DON called bad was told to keep his another staff member He was suspended investigation. He had 9/6/20. LPN-A had cas he was turning in 9/19/20. He was to scheduled shifts on LPN-A was resignin Review of LPN-A's ataff schedules and LPN-A was scheduled 8/27/20, 8/31/20, 9/6/20 LPN-A's timon:  1) 8/27/20, beginning 9/3/20, beginning 19/3/20, beginning 1	had never made concerns beiving assistance from male I-A was unsure how R1 could by the foot of her bed, when ow her bottom, in the middle R1 had been known to refuse he should have been "more On 9/4/20, registered nurse him he was not to go into he. RN-A advised LPN-A he ppropriately. RN-A was going alert her to R1's allegations. It is allegations. It is allegations and worked 9/4/20, 9/5/20, and come to the facility on 9/14/20 in his resignation effective work his upcoming 3 9/17/20 through 9/19/20. If gover the allegations.  August and September, 2020, time clock entries identified he work overnight shifts on 3/20, 9/4/20, 9/5/20, and hecard identified he worked at 6:00 p.m. until 6:46 a.m. at 10:01 p.m. until 6:46 a.m. at 10:02 p.m. through 6:28 at 5:58 p.m. and finishing at employee file identified a	F 609				

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW MANOR HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	TH AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	complaints were ide 9/4/20. The review is worked both units a shift. LPN-A was ide some residents. LP he had made "hurtfur realizing it. It was id what you are doing, a background check identified LPN-A had LPN-A was hired 11 previous background LPN-A had concern coaching's in his file complaint of LPN-A identified by the fac old people, its all in things." R3 reported "skin crawl" and wa weren't around. He I'm back" when he disciplinary actions  Interview on 9/14/20 identified she was n 9/4/20 by R1. R1 has she had seen LPN-at approximately 8:0 noted R1 was afraid R1 stated "I don't w with me. R1 elabora uncomfortable the lacame into her room date) and started "p wears an incontiner was touching her in know what to say to	ge 24 dated 9/14/20, 3 resident entified on 5/5/20, 6/22/20, and identified LPN-A was flexible, and preferred working his night entified having conflicts with N-A was to watch his tone as ul" statements without entified he needed to "explain before you do it." LPN-A had k performed 6/3/20, which d no criminal history reported. /18/19. There was no ad check identified in his file. and problem resolution e. With regard to R3's looking at her vagina, it was ility LPN-A had told R3 "You your head and you imagine d to management he made her s rude when other staff told her in a "creepy voice ereturned to work. No were included in LPN-A's file.  O with nursing assistant (NA)-A nade aware of the incident on ad reported to NA-A and NA-B A report for his shift that day 00 p.m R1 was outside. Staff d to come in and was shaking. ant that [expletive] working ated LPN-A had made he feel ast time he worked. LPN-A during the incident (unknown ooking" at her bottom. R1 nce brief. R1 stated LPN-A appropriately and did not b LPN-A at that time. R1 nocked and scared. R1 had not	F 609				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		` '	SURVEY PLETED	
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F 609	she was afraid. R1 into any further deta NA-A and NA-B left immediately. RN-A spoke to her about room and looked to allegations R1 had witnessed telling LF R1's room. R1 had male staff. There we floor and R1 had no member.  Interview on 9/14/20 identified R1 was a evening of 9/4/20. Laround 8:00 p.m. th NA-B had noticed F doorbell to come bashaking and visibly NA-A and NA-B promatter was. She was proceeded to tell the her room the other advised LPN-A was was wet. He stuck if touched her inapproherself and requires herself to bed etc. She was first admitt discharge soon. NA and advise her of the soon as possible. Resoon as she was do RN-A finished her me speak with R1 in he of R1's room, she was the soon she was do R1's room, she was well with R1 in he of R1's room, she was was well with R1 in he of R1's room, she was was well with R1 in he of R1's room, she was was was well with R1 in he of R1's room, she was was was well with R1 in he of R1's room, she was	ge 25 ne incident before 9/4/20, and began to cry and would not go all with NA-A or NA-B. Both R1's room and advised RN-A went into R1's room and the incident. RN-A exited the be visibly upset by the advised her of. RN-A was PN-A he was not to go into never had any concerns with as another male staff on the concerns with that male staff of at 4:41 p.m. with NA-B smoker and was outside the PN-A had come in early, at day for his shift. NA-A and the was outside and rang the tack into the facility. R1 was upset. "She was petrified". It was upset. "She was petrified". It was upset. "She was petrified". It was upset when he worked. R1 the staff LPN-A had come into might when he worked. R1 checking her to see if she had priately. R1 takes care of the only needed help when the ed. R1 was expected to to assistance to toilet or put the only needed help when the ed. R1 was expected to the need to speak with R1 as N-A was giving meds, and as one, she would speak with R1. Intelligent to LPN-A who was gand advised him he was not gand advised him he was not	F 609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			E SURVEY PLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	0 2 <b>2/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	LPN-A came to wor began shaking. R1 if LPN-A was comin Observation and int p.m., with R1 identifishifts. R1 goes to be incident which R1 reworked but was unstanced by the incident which R1 reworked but was unstanced by the incident work. R1 is awake and rowereport to work. R1 identified the incident dates of 8/28/20 and scheduled weekend into R1's room. She up startled when sharoom. R1 wore O2 off. Her tubing was of her bed. LPN-A pR1 and she advised it was wet on the flot LPN-A then grabbed and came back with advised her the spot feet "looked like percondensation from lookygen. R1 stated she brief. LPN-A showed up the liquid on the dirty. R1 slept with the times and would lay away from the door sudden, R1 felt her was poking his fingestated she was" territorial in the control of the contro	n. Today on 9/14/20, when k, R1 saw him come in. She kept watching the door to see	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	ETREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	0 2 <b>2/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	what they were comsounded like a pensounded like a pensounded like a pensounded like a pensounder like and penetrative was on my butt goir she had never beer LPN-A was not toucherself and had not ocheck her brief fowas "so scared" and talk". LPN-A finally changed?". R1 was replied to her "Alrigistated LPN-A was wouttooks and was not staff had ever touch has never had any at any health facility on the floor was by directly below her buight and again tod LPN-A arrive for word coming back to word LPN-A today arrive and got a "creepy" in ausea. R1 does not can talk! Others [rehome soon and wal Observations during was visibly shaken anger throughout the Interview on 9/14/20 identified she was not sexual abuse fro RN-A stated NA-A advised her they we	sking noises but was unsure hing from. She thought it light nurses use, but never ht of any kind. R1 denied ted her in any way. "His fingering up and down." R1 stated in touched like that before. Shing her brief. R1 toilets reason for LPN-A to attempt or wetness. R1 identified she d "hadn" thad the nerve to said "Do you need to be able to say "No". LPN-A hat then" and left her room. R1 very intentionally touching her of in any way on her brief. No need her that way before. R1 concerns with any male staff or. R1 elaborated the wet spot her feet, not on the floor of tom. R1 was scared that any on 9/14/20, when she saw for work, she started shaking, feeling in her stomach with of feel safe around LPN-A. "I sidents] can't". R1 was going ked independently with cares. In identified was teary eyed and expressed	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E SURVEY PLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	B. WING	ETREET ADDRESS, CITY, STATE, ZIP CODE  100 EAST NINTH AVENUE  LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	requested RN-A spe and NA-B she would passed her medicate up again. RN-A was medication pass, ar RN-A had never medoccasional staff medicate she was working in reported she "just of [LPN-A] gives medit what day the incide was about 2:00 a.m. her O2 would comedoccasionally during door, came in, saw was wet, then advise Without notice, LPN- her covers. That made took his finger and we RN-A asked her what about him. R1 said bathroom door towate being wet. R1 deniet just left. RN-A assurforwarded. R1 also molested as a child RN-A had not include as R1 seemed emb molestation. RN-A has assessment or start stated she called the instruction on how to advised RN-A to wr was nay further information. The DC to her knowledge. The facility after she	d to make sure it was ok, and eak to R1. RN-A advised NA-A d speak to R1 as soon as she tions. NA-A and NA-B followed a almost finished with a dwould be there shortly. It R1 before as she is an amber. On that day of 9/4/20, the back half of the facility. R1 idn't like way things went. He are creeps". She couldn't recall ant occurred, but identified it a or 3:00 a.m. R1 reported	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,			E SURVEY PLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	report to the SA, no crime to the police. the DON and does was an occasional sworked for a while pto work that day, shreporting, advised to she had questions. physically examine of sexual abuse had Review of the 9/4/20 RN-A identified R1 adid not want LPN-A RN-A to speak with was inappropriately was unable to give ther room. R1 was unable to give ther room. R1's nast was on the floor. LFR1 advised she felt (from humidified oxher bedspread and her "butt". LPN-A had was doing. She requirement of the incident. On swork and saw RN-A immediately went to advised her this was review of the staffin 9/4/20, it was identified shifts were 9/3/20 anot have seen LPN-	ever been educated on filing a r reporting a suspicion of a RN-A looks for direction from what she is told. Since RN-A staff person and had not prior to 9/4/20. Upon arriving e was handed the policy on to read through it and ask if RN-A had made no attempt to R1 on 9/4/20 after allegations	F 609			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	` '	SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  CONTROL OF THE PROPERTY OF T	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	shift time-frame he SW agreed the incic likely occurred on 8 of the investigation, had plans to submit that day. The SW conthe allegation likely corroborate there we LPN-A advised her indeed at the end of directly below where "definitely upset above ensure LPN-A had have visibly upset, not reported when she should have told he reviewing the location floor, the SW agreed urine could have derather than directly the middle of the beaway. The SW identification allowed to make reported the poon and admir wearing a brief wou urine on the floor are bedding being wet, not touched her brief buttocks. The SW abuttocks was being would be inconsisted pulled away from he also agreed R1 had and there was no no incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence. The SW and the swan on the floor incontinence incontine	ge 30 ed to occur the last weekend worked before 9/4/20. The dent would have most have /31/20. The SW was in charge which was still ongoing. She the 5 day report to the SA oncluded she couldn't prove occur. The SW could not as actual urine on the floor. The location of the urine was fithe bed by R1's feet and not her hottom was. R1 was but it". The facility wanted to not worked with R1 again. R1 of crying, but anxious SW recalled her interview with R1. What went wrong was he what he was doing". In on of the fluid found on the d, there was no way R1's eposited at the foot of her bed, below her bottom located in ed, approximately over 2 feet diffied the only staff that were borts the to SA were herself, histrator. She also agreed R1 ld have limited deposits of and would have saturated R1's and R1 made no mention of her R1 also claimed LPN-A had bef, but was touching her stroked by LPN-A's fingers ent if her underwear were er body to feel a brief. The SW I been independent to toilet eed to physically check her for SW agreed the DON should uspended LPN-A upon	F 609			

-	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED		
	ENIDII	245378	B. WING	MICHCEM	C <b>09/22/2020</b>
	PROVIDER OR SUPPLIER	NU AUNIN		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLÉTION
F 609	hearing the allegat Facility procedures or the DON could so ther staff were all suspicions of a crir Interview on 9/15/2 practitioner (NP)-A R1's allegation of scalled her, only to a covering nights and the facility on 9/8/2 the allegations at the expect the facility for procedures and not any allegation of all was made aware of surrounding the allegation of all was made aware of surrounding the allegation of all was made aware of surrounding the allegation of all was made aware of surrounding the allegation of all was made aware of surrounding the allegation of all was fully cognitive, next few days.  Interview on 9/15/2 identified she had approximately 10:0 and advised R1 was advised RN-A to find complaint and to capproximately 15 refacility. LPN-A answed him if he "di wanted to file a control of the surrounding the allegation of all was fully cognitive, next few days.	ion and reported to the SA. indicated only the SW, admin submit a report to the SA. No owed to submit reports of me.  20 at 10:20 a.m. with nurse identified she was unaware of sexual abuse. The SW had ask for the medical director wed. She was on call on 9/4/20 d weekends. NP-A rounded at 0, and was not notified about hat time either. She would ollow all policies and of the interviews and events egations. NP-A expected the sident safe and suspend any igation was completed. R1 had illity to care for herself and indently, toilet independently, and was set to go home in the 20 at 10:53 a.m., with the DON received a call on 9/4/20 at 10 p.m., RN-A had called her anted to file a complaint against stated RN-A offered no other e had not asked. The DON and out what prompted such a	F 609		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '				E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		ETREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	0 2 <b>2/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	done nothing wrong she asked LPN-A if inappropriate as he being "gruff" with he at my vagina". The after investigation it LPN-A had been prowould "have to look DON agreed she ha alleged victim (R!)'s was satisfied with L wrongdoing and sta provide cares to R1 by another staff. The LPN-A of the allege immediately suspended residents at risertaliation. The DON investigation immediately to RN-A's with suspended pending The DON agreed he prevent abuse and input all residents at risertaliation. The DON investigation immediately allegation and incident until approximately by the facility R1 regraybe she had not upset. MD had not bused. MD had not bused immediately peallegation. The MD	estion and stated he had and advised her. The reason is he had done done anything had been accused by R3 of er with allegations "He looked DON had filed a report but felt was unsubstantiated as oviding personal cares and "at R3's private parts. The ad knowingly disclosed the identity to LPN-A. The DON PN-A's answer of no ted he was not allowed to unless he was accompanied e DON agreed, advising divictims identity and not ading LPN-A placed R1 and sk for further abuse or N failed to begin an liately and had not returned to 20. At that time, she was ritten report. LPN-A was the facilities investigation. For resolution and actions to failing to follow facility policy isk.  O at 12:27 p.m. with the MD to been made aware of the kimately 9/8/20. He was told corted LPN-A felt her bottom, liked that and was found very known "much more". MD was an notified of R1's identity by	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '			) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	C <b>22/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	agreed LPN-A should policies implemented have been immediated. Interview on 9/15/20 identified she had not suspicion of a crime. The SW had reported board of Nursing.  Review of the 9/4/20 Management policy responsibility of emphysicians, family more promptly report any All allegations were investigated. All repwithout fear or retail Reports were to be absence, reports were nurse. Staff member report an incident of withhold information incidents were discount of 5:00 p.m.), the act at home and inform were to be reported 2 hours after the allemployees accused suspended immediate investigation. For abuse, a thorough of performed by licens investigation was to provided to the administration.	ial further abuse. He also ald have been suspended, and an investigation should ately started.  O at 2:45 p.m. with the SW of called local police for a but would do so right away, and the incident to the MN  O, Reporting Abuse to Facility and the incident of the MN  O, Reporting Abuse to Facility and the incident of suspected abuse, to be reported and thoroughly forts made were to be made attain from facility or its staff, given to the DON. In her are to be made the the charge are shall not knowingly fail to a roffense, screen reports, or a from reporting agencies. If the power of the incident, Allegations a immediately but no later than the egation was made. In the control of abuse were to be ately pending the outcome of the or reports of physical or sexual examination was to be ated nurses. An immediate to be made and a copy	F 609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· '			E SURVEY PLETED	
	NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW MANOR HCC		B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	09/2	C <b>22/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	facility immediately the allegation. The contified and offered investigation. The control of results of the investigation. The control of results of the investigation of the suspended immediate and the SA, local police within 5 days of the mention suspicions reported immediate any other licensing later than 2 hours. Investigations were an accusation of ab Investigations were an accusation of ab Investigate/Prevent CFR(s): 483.12(c)(2) §483.12(c) (1) In respondent of the suspicion of the suspicion of the designated represent accordance with Standard Survey Agency, with incident, and if the appropriate correction of the suspicion	ghly investigated by the but no later than 2 hrs after Ombudsman was to be to participate in the Ombudsman was to be notified estigation. Employees were to ediately. The administrator itten report of the results to medical director and others incident. There was no of a crime were to be ly to local police, the SA, and boards immediately but not There was also no mention to begin immediately following use.  (Correct Alleged Violation 2)-(4)  Inse to allegations of abuse, and or mistreatment, the facility evidence that all alleged ughly investigated.  Ent further potential abuse, and or mistreatment while the rogress.	F 610			10/27/20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
	EVIDII	245378	B. WING		C <b>09/22/2020</b>
NAME OF I	PROVIDER OR SUPPLIER	NO ACAN		TREET ADDRESS, CITY, STATE, ZIP CODE	03/22/20 <u>20</u>
VALLEY	VIEW MANOR HCC			AMBERTON, MN 56152	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION DATE
F 610	review, the facility of thorough investigate abuse, and implement allegations of sexuresident (R1) alleging allegations of sexuresident (R1) alleging allegations include:  Review of the 9/8/2 Agency identified the report identifying the was notified on 9/4 by licensed practical advised staff she heroom. R1 alleged Lendhad come into R1's hours and picked upplied the nasal callegent (D2). LPN-R1 was laying in bealing her bottom". Was going to check action taken by fact advised LPN-A not there was another was suspended perinvestigation.	tion, interview and document failed to immediately begin a cion, prevent further potential tent corrective measures after all abuse were made by 1 of 1 ng sexual abuse by staff.  20 report filed to the State the social worker (SW) filed a tent director of nursing (DON) (20 of inappropriate touching all nurse (LPN)-A to R1. R1 and not wanted LPN-A in her LPN-A, at an unknown date, as room during the overnight to R1's nasal cannula off the ed R1 there was fluid directly finula. R1 advised LPN-A it tensation from humidified A picked up R1's bedding as ed, and "moved his hands LPN-A had not advised R1 he as her for alleged incontinence. Fility was identified as the DON to go into R1's room unless staff person present. LPN-A report on 9/7/20 pending an	F 610	R1 had a risk management inciden created 9-8-20. The MD was notifie 9-9-20. The Police were called on 9-15-20. R1 had her vulnerable aduplan reviewed and updated. Social Services met with R1 on 9-8-20, 9-9 and 9-10-20.  All resident who could communicate interviewed and no other reports of were voiced. For residents who were unable to communicate, their familie were called. This notification will be included in the resident's EMR.  The Administrator, DON and Social Services were in-serviced on thorou investigating abuse allegations and timeliness of investigations. This te was in-serviced on abuse reporting, to make a report in the SA portal, ke resident complaints anonymous and suspension of employee/s upon sus of an allegation. The Administrator, Director of Nursing, ADON and Soc Service Director all have access to the reporting platform and will be responded to reporting allegations of abuse 24 Investigations with any Allegations of abuse 24 Investigations with allegations of abuse 24 Investigations with allegat	ed all care 0-20 e, were abuse re es ghly am how eeping all spicion ial the ensible 1/7. use 1-20 on of
	R1 advised (RN-A) does not want a ma or time) stated he op.m. Over a week a	er the social worker, identified on 9/4/20 at 10:10 p.m. she ale care giver. LPN-A (no date came to work on 9/4/20 at 8:00 ago (unsure of date and time), duty that night of the incident,		abuse and posted at each nurses st by the phone. This schedule will be updated weekly.  Full time facility staff were in-service 9-15-20 and 9-16-20 on the facility p	ed on

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	l'	X3) DATE SURVEY COMPLETED
	ENIDI	245378	B. WING	VI EDGEME	C <b>09/22/2020</b>
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 610	on. LPN-A stated IR1 what she need water. LPN-A wen return, noted a put LPN-A gave R1 he out where it came slightly to check he was trying to figure from. LPN-A patte on her face". LPN-down and cleaned identified R1 frequand voids in her be contact". We (facil caregivers. If he (I medication or attermale nurses will tathem into the room suspension on 9/8 Further investigative marked when he floor, he and LPN-left the room. On sinterviewed by the identified R1 was 9/4/20 and saw LFN-A and NA-B ne since she felt uncowhen the incident occurred, but it was entered her room nasal cannula and LPN-A it was wet for get new tubing. side with her back LPN-A returned, here	had reportedly put her call light he answered it. LPN-A asked ed. R1 stated she wanted cold it to retrieve the water and upon ddle or urine on the floor. For water and was trying to figure from. He lifted R1's cover for bed. LPN-A advised R1 he is out where the urine came do the bed. R1 had a "funny look of A immediately put the covers of up the floor. The notes frently refused to be changed for ithere was no inappropriate ity staff) will care plan "no male of LPN-A) needs to give the medical tx [treatment], aske another female staff with in". LPN-A was notified of his	F 610	for reporting abuse with the emphas reporting incidents immediately. An Staff Meeting will be held on 10-26-2 review the facility abuse policy with emphasis on when Law Enforcement MD, Primary Provider, Ombudsmant guardian will be notified.  Audits on thoroughly investigating at reports and appropriate safety meas are in place and corrective action au will be 2x week for 2 weeks, weekly weeks then monthly x1 year. Audits taken to QAPI by Administrator monthmonths for oversight and to ensure compliance.  Responsible Party: Social Service Director, Director of Nursing or Designation.	All 20 to at, and buse cures dits x3 will be thly x3

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION  S		E SURVEY PLETED
	CNIDII	245378	B. WING	MIEDCEM		C <b>22/2020</b>
NAME OF	PROVIDER OR SUPPLIER	NG AGAN		STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC			200 EAST NINTH AVENUE LAMBERTON, MN 56152		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFESTION  DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	to summon LPN-A other staff has eve in that manner. R1 safe. All staff were Both NA-A and NA NA-B stated on the outside smoking, of shaking. NA-B ask replied "Not really. nervous". Both NA reported she had wher brief by sticking brief without telling wet. After talking to advised LPN-A was Other staff were in knowledge of the ininterviewed for safe concerns with staff notified on 9/8/20 a identified as being indicated in the reputhe facility identified not abusive, nor had he failed at communidentified were mal accompanied by a request. Before ret be inserviced on the residents what he is was to have one-o RN-A was to be insimportance of getti reporting timely. The corrective actions. management had in the suspicion of a denforcement within	that night. R1 declared no r checked her for incontinence reported to the SW she felt good to her except LPN-A.  -B were interviewed on 9/8/20. In ight of 9/4/20, R1 was ame inside and was visibly ed if she was ok to which R1 Seeing [LPN-A] makes me is took R1 to her room. R1 woken up to LPN-A checking ighis finger in the back of her her. R1 denied she had been on RN-A, NA-A and NA-B were is not allowed in R1's room. Iterviewed, but had no incident. Other residents were esty and had no issues or and the medical director was notified on 9/9/20. It was notified on 9/9/20. It was direction". Corrective action	F 610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	ETREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	0 2 <b>2/20<u>20</u></b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	investigation and suppon notification of no mention of approand or the residents care physician.  R1's 8/17/20, admis (MDS) assessment cognitive and requir for toileting.  R1's 8/18/20, progreadmitted to the facil services related to the had pans to return the diagnoses were low weakness, chronic of (COPD).  Interview on 9/14/20 above incident occur knowledge. LPN-A of the incident. R1 the approximately 3:00 tubing and it was lay the end of her bed the room to get R1 new proceeded to hook laying in bed on her from her door. R1 he advised her he was underneath her O2 falling into the liquid to clean it up. R1 was that point". LPN-A pincontinence pad. L	follow policies and ediately beginning and aspending alleged perpetrators an allegation. There was also opriate notification to family a representative, or primary asion Minimum Data Set identified she was fully red extensive assist of 1 staff assessments and session to receive rehabilitative back pain and weakness and nome. Her admitting	F 610			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	2/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	to help her clean up stated he made a "he left the room. Riknown about not restaff members. LPI have leaked urine it the area directly be of the bed, was dry cares. In hindsight, clear" during cares (RN)-A had advised R1's room at any tihad touched R1 in to call the DON and The DON called bawas told to keep his another staff members and the was suspended investigation. He had 9/6/20. LPN-A had as he was turning in 9/19/20. He was to scheduled shifts or LPN-A was resigning Review of LPN-A's staff schedules and LPN-A was scheduled 8/27/20, 8/31/20, 9/6/20 LPN-A's timon:  1) 8/27/20, beginning 3) 9/3/20, beginning 4) 9/4/20, beginning 4) 9/4/20, beginning 5) 9/5/20, beginning a.m.,	R1 if she wanted another staff p, but she refused. LPN-A then joke" to which R1 laughed and 1 had never made concerns eceiving assistance from male N-A was unsure how R1 could by the foot of her bed, when show her bottom, in the middle of the should have been "more of the should have been "more of thim he was not to go into me. RN-A advised LPN-A he appropriately. RN-A was going dialert her to R1's allegations. Take and spoke with LPN-A. He is distance from R1 and have beer give R1 her medications. If on 9/8/20 pending an add worked 9/4/20, 9/5/20, and come to the facility on 9/14/20 in his resignation effective work his upcoming 3 in 9/17/20 through 9/19/20. In gover the allegations.  August and September, 2020, at time clock entries identified the worked ided to work overnight shifts on 1/3/20, 9/4/20, 9/5/20, and mecard identified he worked ing at 6:00 p.m. until 6:46 a.m. ing at 9:58 p.m. until 6:46 a.m. ing at 9:58 p.m. until 6:46 a.m. ing at 8:03 p.m. until 6:46 a.m. ing at 8:03 p.m. until 6:46 a.m. ing at 6:02 p.m. through 6:28 in at 5:58 p.m. and finishing at at 5:58 p.m. and finishing at at 5:58 p.m. and finishing at	F 610			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
NAME OF I	PROVIDER OR SUPPLIER	245378		STREET ADDRESS, CITY, STATE, ZIP CODE	09/2	22/202 <u>0</u>
VALLEY	VIEW MANOR HCC			LAMBERTON, MN 56152		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	performance review complaints were ide 9/4/20. There was rany disciplinary active ducation following. The review identifies both units and prefet LPN-A was identifieresidents. LPN-A was identified residents. LPN-A was identified hendoing, before you do check performed 6/had no criminal hist 11/18/19. There was check identified in hand problem resoluregard to R3's compagina, it was identified in hand problem resoluregard to R3's compagina, it was identified R3 "You old peryou imagine things. he made her "skin cother staff weren't a "creepy voice I'm work. No disciplinar LPN-A's file.  Interview on 9/14/20 identified she was residentified she was resi	employee file identified a dated 9/14/20. 3 resident entified on 5/5/20, 6/22/20, and no indication LPN-A received ons or additional training or those resident complaints. d LPN-A was flexible, worked erred working his night shift. d having conflicts with some as to watch his tone as he had ements without realizing it. It seeded to "explain what you are o it." LPN-A had a background 3/20, which identified LPN-A ory reported. LPN-A was hired as no previous background his file. LPN-A had concernation coaching's in his file. With colaint of LPN-A looking at her fied by the facility LPN-A had ople, its all in your head and "R3 reported to management crawl" and was rude when around. He told her in a back" when he returned to by actions were included in a dreported to NA-A and NA-B A report for his shift that day 00 p.m R1 was outside. Staff of to come in and was shaking, ant that [expletive] working ated LPN-A had made he feel ast time he worked. LPN-A	F 610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	` '	E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		ETREET ADDRESS, CITY, STATE, ZIP CODE 100 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	date) and started "p wears an incontiner was touching her in know what to say to advised she was sh told anyone about to she was afraid. R1 into any further deta NA-A and NA-B left immediately. RN-A spoke to her about room and looked to allegations R1 had witnessed telling LF R1's room. R1 had male staff. There we	ge 41 during the incident (unknown oking" at her bottom. R1 nce brief. R1 stated LPN-A appropriately and did not LPN-A at that time. R1 ocked and scared. R1 had not ne incident before 9/4/20, and began to cry and would not go all with NA-A or NA-B. Both R1's room and advised RN-A went into R1's room and the incident. RN-A exited the be visibly upset by the advised her of. RN-A was PN-A he was not to go into never had any concerns with as another male staff on the o concerns with that male staff	F 610			
	identified R1 was a evening of 9/4/20. L around 8:00 p.m. th NA-B had noticed F doorbell to come bashaking and visibly NA-A and NA-B promatter was. She was proceeded to tell the her room the other advised LPN-A was was wet. He stuck it touched her inapproherself and requires herself to bed etc. She was first admitt discharge soon. NA	at 4:41 p.m. with NA-B smoker and was outside the PN-A had come in early, at day for his shift. NA-A and at was outside and rang the ack into the facility. R1 was upset. "She was petrified". ceeded to ask R1 what the as reluctant to say. R1 e staff LPN-A had come into might when he worked. R1 checking her to see if she his fingers in her brief and opriately. R1 takes care of a no assistance to toilet or put She only needed help when ed. R1 was expected to a A and NA-B left to find RN-A he need to speak with R1 as				

-	ND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   (X2) MULTIPLE CONSTRUCTION   (X3) MULTIPLE CONSTRUCTION   (X4) MULTIPLE CONSTRUCTION   (X5) MULTIPLE CONSTRUCTION   (X6) MULTIPLE CONSTRUCTION   (X7) MULTIPLE CONSTR		COMPLETED		
	CNIDII	245378	B. WING	MI EDGEM	C <b>09/22/2020</b>
	PROVIDER OR SUPPLIER	NO HUNN	IUI	STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152	09/22/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLÉTION
F 610	soon as she was d RN-A finished her is speak with R1 in he of R1's room, she working on that wir to go into R1's room LPN-A came to wo began shaking. R1 if LPN-A was coming Observation and in p.m., with R1 ident shifts. R1 goes to be incident which R1 is worked but was un LPN-A usually work been the previous R1 is awake and room report to work. R1 identified the incided dates of 8/28/20 ar scheduled weeken into R1's room. Sho up startled when sho room. R1 wore O2 off. Her tubing was of her bed. LPN-A R1 and she advise it was wet on the fl LPN-A then grabbe and came back with advised her the spe feet "looked like pe condensation from oxygen. R1 stated brief. LPN-A showe up the liquid on the	RN-A was giving meds, and as one, she would speak with R1. medication pass and went to er room. When RN-A came out went to LPN-A who was and advised him he was not m. Today on 9/14/20, when rk, R1 saw him come in. She kept watching the door to see	F 610		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	` '	SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE  OO EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	away from the door sudden, R1 felt her was poking his finge stated she was" terra anything. He would stop. She heard clic what they were comsounded like a pen saw any flash or light LPN-A had penetrat was on my butt che stated she had never before. LPN-A was toilets herself and hattempt to check he identified she was "the nerve to talk". Let to be changed?". Rereplied to her "Alright stated LPN-A was would be changed?". Rereplied to her "Alright stated LPN-A was would be changed?". Rereplied to her "Alright stated LPN-A was would be changed?". Rereplied to her "Alright stated LPN-A was would be changed?". Rereplied to her "Alright stated LPN-A was would be completed by directly below her benight and again took LPN-A arrive for woo coming back to wor LPN-A today arrive and got a "creepy" for nausea. R1 does not can talk! Others [resent the complete in	on hr left side with her back, facing the wall. All of a covers being lifted and LPN-A ers on her [expletive]. R1 rified". LPN-A had not said start feeling her bottom, then eking noises but was unsure ning from. She thought it light nurses use, but never not of any kind. R1 denied ted her in any way. His finger ck going up and down. R1 er been touched like that not touching her brief. R1 ad no reason for LPN-A to er brief for wetness. R1 so scared" and "hadn't had PN-A finally said "Do you need 1 was able to say "No". LPN-A to the then" and left her room. R1 rery intentionally touching her ot in any way on her brief. No need her that way before. R1 concerns with any male staff or R1 elaborated the wet spot her feet, not on the floor oottom. R1 was scared that any on 9/14/20, when she saw rk. R1 was afraid LPN-A was rk. R1 stated when she saw for work, she started shaking, reeling in her stomach with the feel safe around LPN-A. "I sidents] can't". R1 was going liked independently with cares. It is identified was teary eyed and expressed	F 610			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		( )	(X2) MULTIP		. ,	SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	3E	(X5) COMPLETION DATE
F 610	identified she was not sexual abuse from RN-A stated NA-A and advised her they we R1 was shaking. R1 and the staff wanter requested RN-A spand NA-B she would passed her medicated up again. RN-A was medication pass, ar RN-A had never me occasional staff me she was working in reported she "just d [LPN-A] gives me the what day the incided was about 2:00 a.m. her O2 would come occasionally during door, came in, saw was wet, then advise Without notice, LPN her covers. That matook his finger and the RN-A asked her what about him. R1 said bathroom door towate being wet. R1 denied just left. RN-A assurforwarded. R1 also molested as a child RN-A had not include as R1 seemed emb molestation. RN-A hassessment or start stated she called the	at 6:06 p.m. with RN-A made aware of the allegation m R1 by LPN-A on 9/4/20. and NA-B came up to her and ere walking R1 to her room. I found out LPN-A was on duty d to make sure it was ok, and eak to R1. RN-A advised NA-A d speak to R1 as soon as she tions. NA-A and NA-B followed a almost finished with and would be there shortly. It R1 before as she is an imber. On that day of 9/4/20, the back half of the facility. R1 idn't like way things went. He he creeps". She couldn't recall int occurred, but identified it or 3:00 a.m. R1 reported	F 610			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		` '	SURVEY PLETED
	PROVIDER OR SUPPLIER	245378		STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
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F 610	was nay further info allegations. The DC to her knowledge. If the facility after she had not talked to RI LPN-A. RN-A had not report to the SA, no crime to the police. The DOn and does was an occasional worked for a while provided to work that day, should reporting, advised to she had questions. Physically examine of sexual abuse had Review of the 9/4/2 RN-A identified R1 did not want LPN-A RN-A to speak with was inappropriately was unable to give her room. R1 was unable to give her room. R1 was unable to give her room. R1's nask was on the floor. LFR1 advised she felt (from humidified ox her bedspread and her "butt". LPN-A had was doing. She required Interview and document. She required in the she was doing. She required in the she was a she was a saw RN-A for the incident. On short and saw RN-A for the she was RN-A for the incident. On short and saw RN-A for the she was RN-A f	ite a report and see if there ormation R1 had on the DN had not suspended LPN-A The DON had called back to had spoken with her, but she N-A. The DON spoke to sever been educated on filing a proporting a suspicion of a RN-A looks for direction from what she is told. Since RN-A staff person, she had not prior to 9/4/20. Upon arriving the was handed the policy on the oread through it and ask if RN-A had made no attempt to R1 on 9/4/20 after allegations	F 610			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152		C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	review of the staffing 9/4/20, it was identifuely 1/20, it was identifuely 1/20, it was identifuely 1/20, as she would incident was reported shift time-frame here. SW agreed the incidilikely occurred on 8 of the investigation, had plans to submit that day. The SW controborate there we LPN-A advised here indeed at the end of directly below where "definitely upset above the submit was visibly upset, not reported when she in the SW believed, "should have told here reviewing the location floor, the SW agreed urine could have derather than directly 1/20, the middle of the beaway. The SW iden allowed to make reported when she in the DON and adminimate the DON and adminimate in the floor are bedding being wet. The SW agree bedding being wet.	ge 46 s a reportable incident. In g schedule leading up to fied LPN-A's last scheduled and 8/31/20. LPN-A. R1 would A arrive for that shift on d have been in bed, and the ed to occur the last weekend worked before 9/4/20. The dent would have most have /31/20. The SW was in charge which was still ongoing. She the 5 day report to the SA oncluded she couldn't prove occur. The SW could not as actual urine on the floor. The location of the urine was fithe bed by R1's feet and not e her bottom was. R1 was out it". The facility wanted to not worked with R1 again. R1 of crying, but anxious SW recalled her interview with R1. what went wrong was he r what he was doing". In on of the fluid found on the d, there was no way R1's posited at the foot of her bed, below her bottom located in ed, approximately over 2 feet tified the only staff that were corts the to SA were herself, histrator. She also agreed R1 Id have limited deposits of and would have saturated R1's id R1 made no mention of her R1 also claimed LPN-A had ef, but was touching her agreed, R1's accounts her stroked by LPN-A's fingers	F 610			

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED
245378 B. WII NAME OF PROVIDER OR SUPPLIER  VALLEY VIEW MANOR HCC	O 09/22/2020 STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF CORRECTION (X5) EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  ONLY OF COMPLETION DATE
would be inconsistent if her underwear were pulled away from her body to feel a brief. The SW also agreed R1 had been independent to toilet and there was no need to physically check her for incontinence. The SW agreed the DON should have immediately suspended LPN-A upon hearing the allegation and reported to the SA. Facility procedures indicated only the SW, admin or the DON could submit a report to the SA. No other staff were allowed to submit reports of suspicions of a crime.  Interview on 9/15/20 at 10:20 a.m. with nurse practitioner (NP)-A identified she was unaware of R1's allegation of sexual abuse. The SW had called her, only to ask for the medical director (MD) number last wed. She was on call on 9/4/20 covering nights and weekends. NP-A rounded at the facility on 9/8/20, and was not notified about the allegations at that time either. She would expect the facility follow all policies and procedures and notify a residents provider when any allegation of abuse or neglect is made. NP-A was made aware of the interviews and events surrounding the allegations. NP-A expected the facility keep the resident safe and suspend any staff until an investigation was completed. R1 had improved in the ability to care for herself and could walk independently, toilet independently, was fully cognitive, and was set to go home in the next few days.  Interview on 9/15/20 at 10:53 a.m., with the DON identified she had received a call on 9/4/20 at approximately 10:00 p.m., RN-A had called her and advised R1 wanted to file a complaint against LPN-A. The DON stated RN-A offered no other information and she had not asked. The DON	F 610

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	` '	E SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	facility. LPN-A answasked him if he "did wanted to file a condenied any wrongd of the incident in question done nothing wrong she asked LPN-A inappropriate as he being "gruff" with he at my vagina". The after investigation it LPN-A had been proposed with a my vagina and stapped victim (R!)'s was satisfied with L wrongdoing and stapprovide cares to R1 by another staff. The LPN-A of the allege immediately susper other residents at right retaliation. The DOI investigation immediately until 9/8/alerted to RN-A's we suspended pending the DON agreed he prevent abuse and put all residents at a literal lateral proposed in the facility R1 remaybe she had not incident until appropriate and put she facility R1 remaybe she had not	all her back. After hinutes, the DON called the vered the phone. The DON danything inappropriate" as R1 applaint against him. LPN_A bring, but did advise the DON destion and stated he had grand advised her. The reason of the had done done anything had been accused by R3 of the with allegations "He looked DON had filed a report but felt awas unsubstantiated as oviding personal cares and at R3's private parts. The add knowingly disclosed the add knowingly disclosed the add he was not allowed to unless he was accompanied to a DON agreed, advising ad victims identity and not anding LPN-A placed R1 and sk for further abuse or N failed to begin an diately and had not returned to 20. At that time, she was ritten report. LPN-A was a the facilities investigation. Her resolution and actions to failing to follow facility policy	F 610			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	` '	E SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	the DON, nor that L suspended immedia was immediately per allegation. The MD keep R1 and all oth retaliation or potentiagreed LPN-A should policies implemented have been immediated. Interview on 9/15/20 identified she had not suspicion of a crime The SW had reported Board of Nursing.  Review of the 9/4/20 Management policy responsibility of emphysicians, family reported investigated. All reports were not be absence, reports were not be absence, reports were to be absence, reports were to be absence of the suspicion of the suspi	PN-A had not been ately, or that no investigation arformed upon identifying the agreed the facility failed to er 44 residents safe from ital further abuse. He also ald have been suspended, and an investigation should ately started.  O at 2:45 p.m. with the SW ot called local police for but would do so right away. The incident to the MN  O, Reporting Abuse to Facility identified it was the ployees, consultants, nembers, visitors, etc, to incident of suspected abuse. To be reported and thoroughly forts made were to be made itation from facility or its staff, given to the DON. In her there to be made the the charge are shall not knowingly fail to a from reporting agencies. If overed after hours (8:00 a.m. dmin or DON must be called ed of the incident. Allegations immediately but no later than	F 610			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
	PROVIDER OR SUPPLIER	245378	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152		C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	investigation was to provided to the adm Review of the 9/4/2 identified all reports reported and thorous facility immediately the allegation. The notified and offered investigation. The Cof results of the investigation. The Cof results of the investigation of the suspended immediate any other licensing later than 2 hours. Investigations were an accusation of ab Treatment/Svcs to ICFR(s): 483.25(b) (1) Press Based on the compresident, the facility (i) A resident receiv professional standard pressure ulcers and ulcers unless the indemonstrates that to the compressional standard pressure ulcers and ulcers unless the indemonstrates that to the compressional standard pressure ulcers and ulcers unless the indemonstrates that to the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates that the compressional standard pressure ulcers and ulcers unless the indemonstrates the compressional standard pressure ulcers and ulcers unless the indemonstrates the compressional standard pressure ulcers and ulcers unless the indemonstrates the compressional standard pressure ulcers and ulcers unless the indemonstrates the compressional standard pressure ulcers and ulcers unless the compressional standard pressure ulcers and ulcers unless the compressional stan	sed nurses. An immediate be made and a copy ninistrator.  O, Abuse Investigations policy of abuse were to be promptly ughly investigated by the but no later than 2 hrs after Ombudsman was to be to participate in the Ombudsman was to be notified estigation. Employees were to ediately. The administrator itten report of the results to a medical director and others incident. There was no of a crime were to be ally to local police, the SA, and boards immediately but not There was also no mention to begin immediately following buse.  Prevent/Heal Pressure Ulcer 1)(i)(ii)  egrity sure ulcers.  rehensive assessment of a	F 610			10/27/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	NO ACININ		STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC			200 EAST NINTH AVENUE LAMBERTON, MN 56152		_
0(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	·NI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	Continued From pa	ge 51	F 686			
	by:	NT is not met as evidenced		P2 is no longer a regident at the f	o o ilitu	
	review, the facility famonitor, intervene,	ion, interview and document ailed to appropriately assess, and notify the physician for 1 reviewed who had a pressure		R2 is no longer a resident at the factor her hospitalization she discharanother facility.		
	ulcer. R2 developed identified pressure	d serious illness when a newly ulcer deteriorated significantly ate intervention, resulting in an		All residents with pressure ulcers had their skin care plans reviewed updated. a risk management incic completed for each along with new Braden, Pain assessment and a	and lent was	
	new onset pressure appropriately asses physician for 1 of 1	23/20, when staff identified a ulcer and the facility failed to s, monitor, and notify the resident (R2). R2 suffered enset pressure ulcer leading to		comprehensive skin assessment. attending physician, family and die have been updated on the residen current status.	tician	
	hospitalization, wou admission to hospic illness and expecta administrator was n 3:50 p.m. The IJ wa	nd debridement, and be services with terminal tion of death. The facility otified of the IJ on 9/16/20 at as removed on 9/17/20 at 3:45		Regional nurse consultant in-service RN-B on 9-16-20 on wound status notification risk management and comprehensive skin progress note completion. On 10-21-20 RN-B was in-serviced on Skin and Wound Transcriving RN-B was in-serviced status in the service of the	, e as	
	scope and severity isolated scope that	iance remained at the lower of G-actual harm at an is not immediate jeopardy.		in the facility EMR system. All Lice Staff were in-serviced between 9-1 and 10-22-20 on the Wound Progr	nsed 16-20 am with	
	Findings include:			the process for new or declining w	ounds.	
	intact cognition and of 2 staff with bed n required the use of identified at risk for pressure ulcers at t R2 was incontinent relied on staff to as incontinence briefs.			Residents with new pressure injuri have a risk management incident completed, and new Braden, comprehensive skin assessment a assessment completed. The primprovider and Medical Director or or provider will be notified immediated telephone of any new onset skin in The DON and family will be contact telephone. Request for medical expenses at the time of the patifical	and pain ary n call ly via njury. tted via xam will	
	R2's current face sh	neet identified diagnoses of		be made at the time of the notification	tion.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION (X3) DATE UILDING COMP		
	245378	B. WING	MEDGEME	C <b>09/22/2020</b>	
	PROVIDER OR SUPPLIER  VIEW MANOR HCC	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE .AMBERTON, MN 56152		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 686	Continued From page 52 paralysis on her right side, high blood pressure, chronic kidney disease, muscle weakness, anemia (low iron), difficulty swallowing, stroke, moderate protein-calorie malnutrition and history of skin cancer (forehead).  R2's current care plan identified she had a self-care deficit related to impaired balance, impaired mobility, stroke, right sided paralysis, pain, edema, and pressure ulcer to her sacrum (tailbone). R2 required extensive assistance of 1 to 2 staff to turn and reposition in bed every 2 hours and as needed. R2 had a pressure reducing mattress in her bed and cushion in her wheelchair. Staff were to inform family and the medical provider of any new area of skin breakdown. Staff were to monitor skin issues daily until healed. Staff were to observe, report, and document as needed any changes in skin status to include appearance, color, wound healing, signs and symptoms of infection, wound size and stage.  Interview on 9/16/20 at 10:18 a.m. with family member (FM)-A identified the interim infection control preventionist/wound care registered nurse (RN)-B called her at the end of August 2020. FM-A stated RN-B reported to her R2 had a new onset pressure ulcer the size of nickel. FM-A was unaware if R2's physician had evaluated the wound, or what treatments staff were providing. FM-A stated R2 went to the local hospital on 9/8/20 where she was evaluated and sent for higher acuity care at the regional hospital. Once admitted to the ICU at the regional hospital, the surgeon evaluated the pressure ulcer and deemed it needed to be debrided (areas of dead and infected tissue are removed). Surgery occurred on 9/9/20. FM-A stated the debridement	F 686	The dietician will be notified via e-ma comprehensive skin progress note we completed along with wound site and wound stage. Resident wounds will measured weekly by the wound nurse Daily documentation on the wound we completed buy the staff nurse. New admitted residents with the potential high risk for pressure injury will have skin assessed upon admission. Wo that heal will be followed daily for an additional 2 weeks post closure to elemant wound tissue stability. Nursing staff be notified of residents with new or worsening wounds via 24-hour report the nurse aide care sheet will be upon accordingly.  Licensed Staff will receive a Wound Training on 10-27-20 by AMT Facility Wound Nurse Representative. Licen nurses were in-serviced on the policy changes in condition policy with the fon immediately notifying the MD, preducer risk assessment policy and dais skin checks on those residents with or current pressure injuries. A line lift of the process was placed at each not station for the Licensed staff to refer Other nursing staff were in-serviced 10-26-20.  Audits on daily skin documentation, completion of comprehensive skin assessment, MD notification and family/responsible notification audits be 2x week for 2 weeks, weekly x3 withen monthly x1 year. Audits will be at the monthly x1 year. Audits will be at the monthly x1 year.	vill be d be se. vill be ly for their unds nsure will rt and dated / nsed y for focus essure ly new sting urses ence. on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING COMPLE				
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	J 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	removed from R2's "could see the tailbor reported R2's recturand no further debrid discharged from the admitted to hospice expected to die as a stated the facility has her about the sever needed to be evaluated physician. FM-A stated 2020, and became R2 required a total lable to reposition has Review of R2's 8/25 Assessment identificated the wound pressure ulcer Stag with some fat visible as beefy red with sebloody) drainage. TR2 reported pain dualittle bit" and indicated the wound pressure ulcer Stag with some fat visible as beefy red with sebloody) drainage. TR2 reported pain dualittle bit" and indicated the wound registred pat dry, minydrogel to form a postaff were to cover dressing daily. The and registered dietic There was no ment care plan or increas reviewing potential and Review of R2's 8/25	all sized" area of tissue being sacral area. FM-A stated she one" and said the surgeon m was only half an inch away idement could occur. R2 was a hospital on 9/15/20, and was a services where she was a result of her wound. FM-A and made no prior indication to ity of the wound, or that it ated at any time by a ted R2 had a stroke in April paralyzed on her right side. lift for transfers and was not	F 686	to QAPI by Administrator monthly x months for oversight and to ensure compliance.  Responsible Party: Director of Nurs Designee		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	(X2) MULTIPL A. BUILDING	TIPLE CONSTRUCTION (X3) DATE SUR COMPLETE		
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	treatment.  Review of an 8/25/2 physician from facili "Res (resident) has sacrum, measures appears to be a PI3 The fax also include forehead. MD-B rep dermatologist". The used appropriate m what "OA" and "PI3 there was no requeregarding the press.  Review of an 8/26/2 physician from facili had a pressure injuit with hydrogel with for requested, "Can we [protein supplement for healing?- recomother details were in Staff made no ment examination.  R2's 8/23/20 throug made no mention stassessments as incidentify whether the or worsened, or the and treatment. Then had been informed worsening of R2's p. R2's 9/1/20, wound pressure ulcer was	dentify any additional  20, faxed notification to ity staff to MD-B identified, a new OA (open area) on her 1.3 cm [centimeters] x 0.8 cm, (pressure ulcer, Stage III)". ed information on R2's olied, "please check with re was no mention staff had edical abbreviations to identify" were on the fax. In addition, st for medical examination ure ulcer.  20, faxed notification to ity staff, included notation R2 ry on sacrum- collagen mixed	F 686			

-	OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   (X2) MULTIPLE CONSTRUCTION   A. BUILDING			(X3) DATE SURVEY COMPLETED		
	ENIDII	245378	B. WING	M EDCEM	C <b>09/22</b> /	2020
	PROVIDER OR SUPPLIER  VIEW MANOR HCC	10 ACKIN	2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  .AMBERTON, MN 56152	LIV	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE C	(X5) OMPLETION DATE
F 686	was described as a Per the accompany thickness ulcer now dead tissue) in the identified as an una noted, pain remain unchanged. There notified of the swift or the need to char turning and reposit additional intervent indicated R2's fam what the family me Review of a 9/2/20 R2 had experience indicated her curre (lbs), down from 147.4 % weight loss. severe. Staff noted supplement to professure ulcer, or I loss as an urgent of evaluation and exaresponse to the fax R2's 9/8/20, final with the wound continue center, with serosa had a foul odor. The ulcer measuring 3 ulcer itself now me cm and was still clarather than unstage 9/8/20 along with fax	age 55 0.3 cm. The pressure ulcer peefy red with a black center. It wing pressure ulcer guide, a full of covered with eschar (black wound, should have been stageable ulcer. A decline was ed the same, and orders were was no mention R2's MD was decline in the pressure ulcer, age the care plan or increase ioning or reviewing potential ions. Although the assessment illy was notified, it was unclear mber (FM)-A was notified of.  If fax to the physician identified decent weight was 129.6 pounds a staff did not indicate this was R2 was on a protein mote wound healing." There aff of the worsening of R2's her new onset severe weight concern requiring medical mination. The physician of the continue as above."  The pressure was a new "lump" near the come was a new "lump" near the come was a new "lump" near the come was a Stage III ulcer easile. The MD was notified on amily. Additional information an air mattress on her bed.	F 686			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	. ,	SURVEY PLETED
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	09/2	2 <mark>2/2020</mark>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	entry identified R2 h was noted as lethar only when staff talk it was getting harde R2 had 2 wounds, 1 healing. R2 had a s of her head that was wound not healing a blood pressure 60/4 (mm/hg) (normal 12 degrees Fahrenheit 16-20) and oxygen son room air. No othe documented as ass now called the MD obe sent to the hospillar ho	O, SBAR change of condition had drastically declined. R2 gic and would open her eyes to her. R2 was not eating and r to give her oral medication. It is surgical. Wounds are not surgical wound on her left side is not healing and a coccyx as well. R2's vital signs were so millimeters of mercury (20/80) temperature of 97.3 (F), respiratory 20 (normal saturation (SPO2) was 91% er assessment vitals were essed. Staff identified they on call. The MD ordered R2 sidentified on 8/23/20, R2 symptoms of sepsis as follows: e (T) was documented at or F during 6 days from 8/23/20 ase days identified were 29/20, 8/31/20, 9/4/20, and est temperature recorded as orded as over 90 bpm on with the highest documented dily declined from the normal from 8/31/20 through 9/8/20	F 686			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	STRUCTION (X3) DATE SUR COMPLETE		
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	1 2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	09/2	C 22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	She was unaware on a new onset pre- to notify her of the ridentify appropriate MD-B was not mad due to the facility us abbreviation on the received by herself agreed any new on called to the provide changes in size, co been sent to clinic of came to the facility wound care clinic in have requested and for R2 at the clinic. would have immedi she lives within 15 ri her expectation the procedures as well and treat pressure of the facility had a tra	ge 57 R2's primary care provider. If the need for an assessment assure ulcer. Staff never called need to come to the facility or treatment. NP-C's partner, e aware of the pressure ulcer sing non-approved medical ir fax. No phone call was ever or her partner MD-B. NP-C set pressure ulcer needs to be ear immediately, as well as any lor, depth etc. R2 should have or NP-C or MD-B would have to assess R2. There is a local a Redwood Falls. Staff could define the the the the the the the the the th	F 686			
	11:24 a.m., with RN interim infection con nurse while the per leave. RN-B had misshe was given the I wound care assess medical record. She and had learned the RN. The facility pro-assessments 1 x per leave.	ment review on 9/16/20 at I-B identified she was the atrol preventionist and wound manent staff was on a medical inimal training on wound care. book which mimicked the ment in the facility electronic a had no formal IC training at position on the job as an ocedure was to perform the er week. The delay from of any formal assessment was if not performing.				

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	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	2	TREET ADDRESS, CITY, STATE, ZIP CODE  00 EAST NINTH AVENUE  AMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	weekly assessment documented during identify changes of Staff did not call proulcers, nor did they ulcers. Faxes were RN-B identified in the 8/25/20, "OA" stood "pressure ulcer, Star PI3 were not approput eluded it was shoroviders were called emergency per RN-regional hospital phe ED visit and agreed assess R2's wound signs and symptom looking back at her septic while she remarker.	had to wait for the official to No documentation was daily dressing changes to condition of pressure ulcers. Eviders for new onset pressure call for worsening of pressure sent vs. calling the provider. The fax sent to the MD on the for "open area" and PI3 was age 3". RN-B agreed OA and priate medical abbreviations nort-hand. The only time ed was if a situation was an eb. RN-B reviewed the totos of R2's wound from the lashe had failed to accurately a RN-B was unaware of the sof sepsis. RN-B agreed, vital signs, R2 was indeed mained at the facility prior to	F 686			
	record identified R2 emergent medical econdition. R2 arrive level of consciousne a gradual decline in last several days. Seacral ulcer and she (cancer) excision of August. Upon admit 100 degrees T, HR 92% SpO2. R2 had wound in the coccythere appeared to be surrounding area (in forward) of erythem	20, local hospital medical was sent to the ED for evaluation for declining d at 7:11 p.m. with decreased less and hypotension. R2 had her overall health over the he has 2 known wounds. A le is status post basal cell fithe left frontal scalp in mid ssion, R2's vital signs were 104, respiratory rate (RR) 24, a large deep foul-smelling a raea. The MD documented the necrotic tissue and hability to flex the neck late. Blood cultures were taken.				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		E CONSTRUCTION	COMPLETED		
	245378	B. WING	/I EDGEM	C <b>09/22/2020</b>	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	03/22/20 <u>20</u>	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION	
F 686	hypotension and known wounds led to a fairly expedited evaluation for sepsis. There is very foul-smelling sacral wound is the likely cause of our presumed sepsis." R2 was diagnosed with sepsis. Plans were made to transport R2 to the regional hospital for higher level of care (ICU). R2's lab values identified severe infection. Her white blood cell count was 24.7 (normal 3.5 to 10.5).  Review of R2's 9/8/20, regional hospital medical	F 686			
	record identified she was admitted to the regional hospital on 9/8/20 when she was transported for higher acuity needs. R2 had diagnoses of sepsis with septic shock related to her pressure ulcer, infected pressure ulcer, atrial fibrillation (abnormal heart murmur), lactic acidosis related to sepsis, heart attack related to lack of decreased blood flow, acute renal failure possibly related to dehydration related to poor oral intake in addition to sepsis, septic encephalopathy (brain dysfunction related to sepsis), blood cooagulopathy (blood clotting) possibly related to sepsis, difficulty swallowing, moderate protein malnutrition and palliative care. The hospital MD identified R2 resided at the long-term care facility. Over the past couple of days she had become increasingly lethargic. She was found to have sepsis due to an infected pressure ulcer. She was transferred from the local hospital for additional care. Surgery was consulted for debridement (done 9/9) which found a necrotic full thickness ulcer, measuring 12 cm x 12 cm x 3.5 cm. A palliative care consultation was requested. R2 was transferred out of the Coronary Intensive Care Unit. (CICU). After a palliative care meeting, R2 was transferred to hospice care. On the day of discharge of 9/15/20, R2 appeared in poor state of health and				

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Interview on 9/16/20 identified R2 had be non-healing wound cancer on her foreh procedure to remove was left open to head been aware of R2's faxed on 8/25/20 arasking her for treatm MD-B referred them unsure what "OA" a not standard medicalled the facility released to dermate and treatment had be deferred to dermate not made aware of and no mention was its onset or worseninever called and as was advised some admitted to the reginospital MD, R2 had pressure ulcer. MD-she was unaware a "gravity of the situational conditional provider to ensure able to be conveyed plan and identify if a required.  Interview and docur 10:00 a.m. with NP-provider while R2 coneighboring nursing	ge 60 ill be discharged on hospice. D at 12:03 p.m., with MD-B een seeing dermatology for She was diagnosed with skin lead. R2 had a surgical re the cancer and the area real. MD-B had not seen or pressure ulcer. She was read thought the facility was ment orders for her forehead. To dermatology. She was real abbreviations. She had real. MD-B again re	F 686			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER	245378	B. WINGS	TREET ADDRESS, CITY, STATE, ZIP CODE 00 EAST NINTH AVENUE AMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	appropriately and tin intervened and notiful That resulted in R2' intervention, NP-Ab terminally ill now on care plan and identiful mattress and cushic additional interventiful cer. R2 was to be to discharge every additional tissue to pressure ulcers. White identified that turning with normal tissue to pressure ulcers. White identified, the care packedule should ha was turned and reported.	ge 61 ely preventable" had staff mely assessed, monitored, fied the physician via phone. s decline. Had R2 had early believed she may not be hospice. NP-A reviewed R2's ified other than a pressure on, there were no other ons to prevent the pressure turned and repositioned prior 2 hours and as needed. NA-A ng schedule was for a resident olerance and not at risk for nen R2's pressure ulcer was olan and repositioning ve been updated to ensure R2 ositioned, sacrum offloaded, pdated to reflect her higher	F 686			
	1130 a.m with the unaware of R2's predischarge. The DOI wound needed to be physician called, an revised to increase further breakdown. never fax a physicia is identified. The DO appropriately trained assessments. The Inneeded to be check assessments docur to identify worsening provider. The DON assessment, moniton notification led to R2	ment review on 9/17/20 at DON identified she was essure ulcer prior to her N agreed, any new onset e assessed immediately, d interventions reviewed and levels of care to prevent The DON agreed staff should an when a change of condition DN agreed RN-B was not d to perform pressure ulcer DON agreed all wounds ted daily, and results of those mented so staff would be able g condition and alert the agreed the facility's lack of bring, intervention and 2's worsening pressure ulcer				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING		. ,	X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378		STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	22/20 <u>20</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	and agreed the woulthe same condition staff had assessed had not monitored in performance in preshad she ensured porfollowed.  Review of the facilit Risk Assessment porthe procedure was assessment and ide of developing pressindicated pressure of when a resident renfor an extended perpressure or a decreto that area, which opressure ulcers were discovered, they hall arger, painful and in serious skin condition to routinely assess the resident's skin post care policy for any sirritation or breakdo report any signs of a the supervisor. Staff inspections with dain notified to inspect this dentified. Nurses we assessments at lead Because a resident pressure ulcer within pressure, the at-risk identified and have promptly to attempt	ne regional hospital record and would have appeared in hours earlier when facility it prior to transfer. The DON RN-B's training or saure ulcer assessment, nor olicies and procedures were by's 9/1/20, Pressure Ulcer colicy identified the purpose of to provide guidelines for the entification of residents at risk ure ulcers. The policy ulcers were usually formed nained in the same position iod of time causing increased ase of circulation (blood flow) destroys the tissues. If we not treated when we the potential to become and document the condition of the potential to become and document the condition of the facility wound and skin signs and symptoms of who. Staff were to immediately a developing pressure ulcer to fewere to perform routine skin by care. Nurses were to be ne skin if skin changes are	F 686			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER VIEW MANOR HCC	245378	1 2	ETREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE LAMBERTON, MN 56152	09/2	2 <mark>2/2020</mark>	
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F 686	medical record utiliz  1) The type of asse 2) The date and timprovided, if appropr 3) The name and timprovided, if appropr 3) The name and timprovided the 4) Any change in thidentified tied. 5) The condition of and location of any identified. 6) How the resident his/her ability to par 7) Any problems or resident related to to fanything unusual 8) The signature and recording the data. 9) Documentation in MD notification if nechange of plan of control to the total moted with change of Staff were to report accordance with facts standards of practic of skin concern, and the family, guardiant an assessment, if anoted, initiate a (present the proceed to interventions individually procedure.	be recorded in the resident's zing facility forms: ssment conducted. The and type of skin care iate. The (or initials) of the individual assessment. The resident's condition. The resident's skin like the size red or tender areas, if the resident's skin like the size red or tender areas, if the resident shade by the he procedure or observations exhibited by the resident. The ditle (or initials) of the person medical record addressing the skin alteration noted with the are if indicated. The addressing family, guardian ion if new skin alteration is of the care plan if indicated. The other information in collity policy and professional the care plan if indicated. The other information in the other information in the care plan if indicated. The other information in	F 686				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	CNIDII	245378	B. WING	MI EDGEM	C 09/22/2020
	PROVIDER OR SUPPLIER		IUI	STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152	03/22/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPRIES OF	D BE COMPLÉTION
F 686	medical director for The immediate jeo 9/17/20, when it co interview and docu resident pressure a documentation had Assessments were with current pressure measurement. Car and revised as applicatified systems newly admitted resulcers. Finally, the	pardy was removed on ould be verified by observation, ment review, protocols for allcer assessment and been reviewed and updated. e completed for all residents	F 686		

(X6) DATE

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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 9/14/20 through 9/22/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

correction that you have reviewed these orders, and identify the date when they will be completed.

Electronically Signed 10/21/20

TITLE

STATE FORM 6899 GT4K11 If continuation sheet 1 of 31

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` 'c		DATE SURVEY		
ANDIEAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:			
_ _		00731	B. WING	$+++\setminus \setminus \Delta$	C <b>09/22/202<u>0</u></b>	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From pa	age 1	2 000			
	SUBSTANTIATED: with licensing order The facility is enroll	plaint was found to be H5378022C and H5378023C rs issued at S900 and S1980.  led in ePOC and therefore a				
	page of state form.	uired at the bottom of the first				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		10/27/20	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the dursing care plan which				
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review, the facility f monitor, intervene, of 6 residents (R2) ulcer. R2 developed identified pressure	ent is not met as evidenced ion, interview and document ailed to appropriately assess, and notify the physician for 1 reviewed who had a pressure d serious illness when a newly ulcer deteriorated significantly ate intervention, resulting in an		R2 is no longer a resident at the facility.  After her hospitalization she discharge another facility.  All residents with pressure ulcers have had their skin care plans reviewed and updated. a risk management incident	d to	

Minnesota Department of Health

STATE FORM 6899 GT4K11 If continuation sheet 2 of 31

Minnesota Department of Health					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY	VIEW MANOR HCC		NINTH AVE		
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2 900	Continued From particular immediate jeopard Findings include:  R2's 7/16/20, quarticate cognition and of 2 staff with bed required the use of identified at risk for pressure ulcers at R2 was incontinent relied on staff to as incontinence briefs.  R2's current face sparalysis on her rigical chronic kidney disanemia (low iron), moderate protein-cof skin cancer (fore R2's current care paself-care deficit relimpaired mobility, spain, edema, and patential formation in the company of the	age 2  y for R2.  terly MDS identified R2 had derequired extensive assistance mobility and transfers. R2 fa total mechanical lift. R2 was repressure ulcers and had no the time of the assessment. It of bowel and bladder and seist in toileting and wore seist in toileting and wore sease, muscle weakness, difficulty swallowing, stroke, realorie malnutrition and history enead).  In the property of th	2 900	completed for each along with ne Braden, Pain assessment and a comprehensive skin assessment attending physician, family and di have been updated on the resider current status.  Regional nurse consultant in-serv RN-B on 9-16-20 on wound status notification risk management and comprehensive skin progress not completion. On 10-21-20 RN-B win-serviced on Skin and Wound T the facility EMR system. All Licenwere in-serviced between 9-16-20 10-22-20 on the Wound Program process for new or declining wour Residents with new pressure injurhave a risk management incident completed, and new Braden, comprehensive skin assessment assessment completed. The prin provider and Medical Director or oprovider will be notified immediate telephone of any new onset skin in The DON and family will be contatelephone. Request for medical elephone. Request for medical elephone at the time of the notifical The dietician will be notified via ecomprehensive skin progress not completed along with wound site wound stage. Resident wounds as a session wounds wounds wounds wounds wounds wounds wounds wounds as a session wounds	The etician nt's riced s, e was raining in sed Staff o and with the nds. ries will and pain nary on call ely via njury. ceted via exam will etion. email. A e will be and will be and will be
	status to include aphealing, signs and size and stage.	needed any changes in skin opearance, color, wound symptoms of infection, wound 20 at 10:18 a.m. with family		measured weekly by the wound n Daily documentation on the woun completed buy the staff nurse. N admitted residents with the poten- high risk for pressure injury will ha skin assessed upon admission. N	d will be ewly tial for ave their

6899

Minnesota Department of Health STATE FORM

Interview on 9/16/20 at 10:18 a.m. with family member (FM)-A identified the interim infection

If continuation sheet 3 of 31 GT4K11

that heal will be followed daily for an

Minneso	ota Department of H	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
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2 900	Continued From pa	age 3	2 900			
	control preventionic (RN)-B called her a FM-A stated RN-B onset pressure ulcunaware if R2's ph wound, or what tre FM-A stated R2 we 9/8/20 where she whigher acuity care admitted to the ICL surgeon evaluated deemed it needed and infected tissue occurred on 9/9/20 resulted in a "softb removed from R2's "could see the tailb reported R2's rectuand no further deb discharged from thadmitted to hospice expected to die as stated the facility hher about the seven needed to be evaluable to reposition in Review of R2's 8/2 Assessment identifirst identified on 8, indicated the woun pressure ulcer Statwith some fat visib as beefy red with s bloody) drainage. R2 reported pain decrease in	st/wound care registered nurse at the end of August 2020. reported to her R2 had a new er the size of nickel. FM-A was ysician had evaluated the atments staff were providing. In to the local hospital on was evaluated and sent for at the regional hospital. Once J at the regional hospital, the the pressure ulcer and to be debrided (areas of dead are removed). Surgery. FM-A stated the debridement all sized" area of tissue being a sacral area. FM-A stated she one" and said the surgeon are was only half an inch away ridement could occur. R2 was a result of her wound. FM-A and made no prior indication to rity of the wound, or that it lated at any time by a lated R2 had a stroke in April paralyzed on her right side. lift for transfers and was not		additional 2 weeks post closure to wound tissue stability. Nursing stability in the work wounds via 24-hour report and the aide care sheet will be updated accordingly.  Licensed Staff will receive a Word Training on 10-27-20 by AMT Far Wound Nurse Representative. A Licensed nurses were in-service policy for changes in condition pothe focus on immediately notifying pressure ulcer risk assessment and aily skin checks on those residence of the process was placed nurses station for the Licensed streference. Other Nursing staff with in-serviced on 10-26-20.  Audits on daily skin documentatic completion of comprehensive sk assessment, MD notification of a changes in resident condition and family/responsible notification and be 2x week for 2 weeks, weekly then monthly x1 year. Audits will to QAPI by Administrator monthly months for oversight and to ensurompliance.  Responsible Party: Director of N Designee	staff will be worsening he nurse  und cility All don the olicy with no olicy and ents with A line at each staff to ere  on, in acute d didits will x3 weeks be taken y x3 ure	

Minnesota Department of Health

STATE FORM 6899 GT4K11 If continuation sheet 4 of 31

PRINTED: 10/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 Continued From page 4 2 900 Tylenol, gabapentin and Tramadol for pain. Wound treatment was identified as: clean as ordered, pat dry, mix collagen powder with a hydrogel to form a paste and apply to the wound. Staff were to cover the wound and change the dressing daily. The medical doctor (MD), family. and registered dietician were notified on 8/25/20. There was no mention of the need to change the care plan or increase turning and repositioning or reviewing potential additional interventions. Review of R2's 8/25/20, progress notes identified no phone call was made to R2's MD to request assessment or to identify any additional treatment. Review of an 8/25/20, faxed notification to physician from facility staff to MD-B identified. "Res (resident) has a new OA (open area) on her sacrum, measures 1.3 cm [centimeters] x 0.8 cm, appears to be a PI3 (pressure ulcer, Stage III)". The fax also included information on R2's forehead. MD-B replied, "please check with dermatologist". There was no mention staff had used appropriate medical abbreviations to identify what "OA" and "PI3" were on the fax. In addition, there was no request for medical examination regarding the pressure ulcer. Review of an 8/26/20, faxed notification to physician from facility staff, included notation R2 had a pressure injury on sacrum- collagen mixed with hydrogel with foam dressing. Staff requested. "Can we also have order for Alginaide

6899

Minnesota Department of Health STATE FORM

examination.

[protein supplement used for healing] twice daily for healing?- recommended by dietary nurse." No other details were made or asked of the provider. Staff made no mention for the need for medical

> GT4K11 If continuation sheet 5 of 31

PRINTED: 10/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 900 Continued From page 5 2 900 R2's 8/23/20 through 9/8/20, progress notes made no mention staff had performed daily assessments as indicated per care plan to identify whether the wounds increased, changed, or worsened, or the need for medical evaluation and treatment. There was no mention the MD had been informed of the progression or worsening of R2's pressure ulcer after 8/25/20. R2's 9/1/20, wound assessment identified the pressure ulcer was still classified as a stage III pressure ulcer, which had increased in size to 206 cm x 1.5 cm x 0.3 cm. The pressure ulcer was described as beefy red with a black center. Per the accompanying pressure ulcer guide, a full thickness ulcer now covered with eschar (black dead tissue) in the wound, should have been identified as an unstageable ulcer. A decline was noted, pain remained the same, and orders were unchanged. There was no mention R2's MD was notified of the swift decline in the pressure ulcer, or the need to change the care plan or increase turning and repositioning or reviewing potential additional interventions. Although the assessment indicated R2's family was notified, it was unclear what the family member (FM)-A was notified of. Review of a 9/2/20, fax to the physician identified R2 had experienced weight loss. The fax indicated her current weight was 129.6 pounds (lbs), down from 140.4 lbs in 1 month, totaling a 7.4 % weight loss. Staff did not indicate this was severe. Staff noted R2 was on a protein

6899

Minnesota Department of Health STATE FORM

supplement to promote wound healing." There was no mention staff of the worsening of R2's pressure ulcer, or her new onset severe weight loss as an urgent concern requiring medical evaluation and examination. The physician response to the fax noted "continue as above."

> GT4K11 If continuation sheet 6 of 31

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 900 Continued From page 6 2 900 R2's 9/8/20, final wound assessment identified the wound continued to have a beefy red, black center, with serosanguinous drainage but now had a foul odor. There was a new "lump" near the ulcer measuring 3 cm x 2.2 cm. The pressure ulcer itself now measured 4.9 cm x 2.0 cm x 1.2 cm and was still classified as a Stage III ulcer rather than unstageable. The MD was notified on 9/8/20 along with family. Additional information only listed R2 had an air mattress on her bed. Review of the 9/8/20, SBAR change of condition entry identified R2 had drastically declined. R2 was noted as lethargic and would open her eyes only when staff talk to her. R2 was not eating and it was getting harder to give her oral medication. R2 had 2 wounds, 1 is surgical. Wounds are not healing. R2 had a surgical wound on her left side of her head that was not healing and a coccyx wound not healing as well. R2's vital signs were blood pressure 60/40 millimeters of mercury (mm/hg) (normal 120/80) temperature of 97.3 degrees Fahrenheit (F), respiratory 20 (normal 16-20) and oxygen saturation (SPO2) was 91% on room air. No other assessment vitals were documented as assessed. Staff identified they now called the MD on call. The MD ordered R2 be sent to the hospital. Review of R2's vital signs identified since R2's pressure ulcer was identified on 8/23/20, R2 showed signs and symptoms of sepsis as follows: 1) R2's temperature (T) was documented at or below 96.8 degrees F during 6 days from 8/23/20 through 9/8/20. Those days identified were 8/26/20, 8/27/20, 8/29/20, 8/31/20, 9/4/20, and 9/7/20 with the lowest temperature recorded as

Minnesota Department of Health

95.9 on 9/7/20.

2) R2's HR was recorded as over 90 bpm on 9/7/20 and 9/8/20 with the highest documented

STATE FORM 6899 GT4K11 If continuation sheet 7 of 31

PRINTED: 10/30/2020

**FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 7 2 900 2 900 rate at 98 bpm. 3) R2's SpO2, steadily declined from the normal 95-98%, 16 times from 8/31/20 through 9/8/20 and ranged from 90 % to 94%. 4) R2's systolic blood pressure started to decline on 9/1/20, when it was documented her blood pressure was 91/58, down from 120's over 60's to 60/40 on the day she was sent to the ER. Interview on 9/16/20 at 10:36 a.m., with NP-C identified she was R2's primary care provider. She was unaware of the need for an assessment on a new onset pressure ulcer. Staff never called to notify her of the need to come to the facility or identify appropriate treatment. NP-C's partner, MD-B was not made aware of the pressure ulcer due to the facility using non-approved medical abbreviation on their fax. No phone call was ever received by herself or her partner MD-B. NP-C agreed any new onset pressure ulcer needs to be called to the provider immediately, as well as any changes in size, color, depth etc. R2 should have been sent to clinic or NP-C or MD-B would have came to the facility to assess R2. There is a local wound care clinic in Redwood Falls. Staff could have requested and then made an appointment for R2 at the clinic. Had NP-C been called, she would have immediately come to the facility as she lives within 15 minutes of the facility. It was her expectation the facility follow policies and procedures as well as best practices to prevent and treat pressure ulcers. NP-C was unaware if the facility had a trained wound care nurse, or if RN-B had been appropriately trained to perform an assessment.

Minnesota Department of Health

Interview and document review on 9/16/20 at 11:24 a.m., with RN-B identified she was the interim infection control preventionist and wound nurse while the permanent staff was on a medical

STATE FORM 6899 GT4K11 If continuation sheet 8 of 31

PRINTED: 10/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 900 Continued From page 8 2 900 leave. RN-B had minimal training on wound care. She was given the book which mimicked the wound care assessment in the facility electronic medical record. She had no formal IC training and had learned that position on the job as an RN. The facility procedure was to perform assessments 1 x per week. The delay from 8/23/20 to 8/25/20 of any formal assessment was caused by floor staff not performing assessments. They had to wait for the official weekly assessment. No documentation was documented during daily dressing changes to identify changes of condition of pressure ulcers. Staff did not call providers for new onset pressure ulcers, nor did they call for worsening of pressure ulcers. Faxes were sent vs. calling the provider. RN-B identified in the fax sent to the MD on 8/25/20, "OA" stood for "open area" and PI3 was "pressure ulcer, Stage 3". RN-B agreed OA and PI3 were not appropriate medical abbreviations but eluded it was short-hand. The only time providers were called was if a situation was an emergency per RN-B. RN-B reviewed the regional hospital photos of R2's wound from the ED visit and agreed she had failed to accurately assess R2's wound. RN-B was unaware of the signs and symptoms of sepsis. RN-B agreed, looking back at her vital signs, R2 was indeed septic while she remained at the facility prior to her transfer.

Minnesota Department of Health

Review of R2's 9/8/20, local hospital medical record identified R2 was sent to the ED for emergent medical evaluation for declining condition. R2 arrived at 7:11 p.m. with decreased level of consciousness and hypotension. R2 had a gradual decline in her overall health over the last several days. She has 2 known wounds. A sacral ulcer and she is status post basal cell (cancer) excision of the left frontal scalp in mid

STATE FORM 6899 GT4K11 If continuation sheet 9 of 31

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

00731

B. WING

C 09/22/2020

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: \_

### 200 EAST NINTH AVENUE

VALLEY	VIEW MANOR HCC	ST NINTH AVEN ERTON, MN 561		
(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) COMPLETE DATE
2 900	Continued From page 9  August. Upon admission, R2's vital signs were 100 degrees T, HR 104, respiratory rate (RR) 292% SpO2. R2 had a large deep foul-smelling wound in the coccyx area. The MD documented there appeared to be necrotic tissue and surrounding area (inability to flex the neck forward) of erythema. Blood cultures were taker The MD determined "the combination of fever, hypotension and known wounds led to a fairly expedited evaluation for sepsis. There is very foul-smelling sacral wound is the likely cause of our presumed sepsis." R2 was diagnosed with sepsis. Plans were made to transport R2 to the regional hospital for higher level of care (ICU). R2's lab values identified severe infection. Her white blood cell count was 24.7 (normal 3.5 to 10.5).	n.		
	Review of R2's 9/8/20, regional hospital medical record identified she was admitted to the region hospital on 9/8/20 when she was transported for higher acuity needs. R2 had diagnoses of sepsis with septic shock related to her pressure ulcer, infected pressure ulcer, atrial fibrillation (abnormal heart murmur), lactic acidosis related to sepsis, heart attack related to lack of decreased blood flow, acute renal failure possible related to dehydration related to poor oral intake in addition to sepsis, septic encephalopathy (bradysfunction related to sepsis), blood cooagulopathy (blood clotting) possibly related to sepsis, difficulty swallowing, moderate protein malnutrition and palliative care. The hospital MD identified R2 resided at the long-term care facility over the past couple of days she had become increasingly lethargic. She was found to have sepsis due to an infected pressure ulcer. She was transferred from the local hospital for additional care. Surgery was consulted for debridement (done 9/9) which found a necrotic	al r s s s s s s s s s s s s s s s s s s		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 10 of 31 GT4K11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.	FTN		
_		00731	B. WING	<del></del>		2/202 <u>0</u>
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 900	full thickness ulcer, 3.5 cm. A palliative requested. R2 was Coronary Intensive palliative care meet hospice care. On the R2 appeared in pooterminally ill. She was Interview on 9/16/2 identified R2 had be non-healing wound cancer on her foreh procedure to remove was left open to her been aware of R2's faxed on 8/25/20 ar asking her for treating MD-B referred them unsure what "OA" and standard medic called the facility re She was advised the and treatment had deferred to dermate not made aware of and no mention waits onset or worsen never called and as was advised some admitted to the reginospital MD, R2 hapressure ulcer. MD she was unaware a "gravity of the situal change of condition a provider to ensure able to be conveyed."	measuring 12 cm x 12 cm x care consultation was a transferred out of the Care Unit. (CICU). After a ting, R2 was transferred to be day of discharge of 9/15/20, or state of health and ill be discharged on hospice.  O at 12:03 p.m., with MD-B deen seeing dermatology for a She was diagnosed with skin head. R2 had a surgical we the cancer and the area al. MD-B had not seen or a pressure ulcer. She was and thought the facility was ment orders for her forehead. In to dermatology. She was and "PI3" were as they were all abbreviations. She had lated to R2's forehead wound. The facility had a wound team been initiated. MD-B again blogy. MD-B stated she was R2's new onset pressure ulcers ever made to her regarding ing condition. Facility staff had sked her to examine R2. MD-B time after R2 had been onal hospital by the local discome septic from a B advised the hospital MD and had never known about the tion". MD-B expected any was to be called, not faxed to be accurate information was dit to make the best treatment a medical examination was	2 900			

6899

Minnesota Department of Health STATE FORM

PRINTED: 10/30/2020

**FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

2 900

Interview and document review on 9/17/20 at 10:00 a.m. with NP-A identified she was now R2's provider while R2 currently resided at a neighboring nursing home on hospice. NP-A saw R2 vesterday on 9/16/20, and stated the pressure ulcer "was completely preventable" had staff appropriately and timely assessed, monitored, intervened and notified the physician via phone. That resulted in R2's decline. Had R2 had early intervention, NP-A believed she may not be terminally ill now on hospice. NP-A reviewed R2's care plan and identified other than a pressure mattress and cushion, there were no other additional interventions to prevent the pressure ulcer. R2 was to be turned and repositioned prior to discharge every 2 hours and as needed. NA-A identified that turning schedule was for a resident with normal tissue tolerance and not at risk for pressure ulcers. When R2's pressure ulcer was identified, the care plan and repositioning schedule should have been updated to ensure R2 was turned and repositioned, sacrum offloaded, and her care plan updated to reflect her higher need for care.

Interview and document review on 9/17/20 at 1130 a.m., with the DON identified she was unaware of R2's pressure ulcer prior to her discharge. The DON agreed, any new onset wound needed to be assessed immediately, physician called, and interventions reviewed and revised to increase levels of care to prevent further breakdown. The DON agreed staff should never fax a physician when a change of condition is identified. The DON agreed RN-B was not appropriately trained to perform pressure ulcer assessments. The DON agreed all wounds needed to be checked daily, and results of those assessments documented so staff would be able

Minnesota Department of Health

2 900

Continued From page 11

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00731	B. WING		09/2	; 2/2020
NAME OF	PROVIDER OR SUPPLIER		DDECC CITY O	STATE, ZIP CODE		
NAIVIE OF	FNOVIDEN ON SUFFLIEN		NINTH AVE			
VALLEY	VIEW MANOR HCC		TON, MN 56			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
2 900	Continued From pa	age 12	2 900			
		ng condition and alert the Nagreed the facility's lack of				
		toring, intervention and				
		R2's worsening pressure ulcer The DON reviewed the				
		the regional hospital record				
		und would have appeared in				
		n hours earlier when facility I it prior to transfer. The DON				
	had not monitored					
	performance in pre	essure ulcer assessment, nor				
	had she ensured p followed.	olicies and procedures were				
	ioliowed.					
		ity's 9/1/20, Pressure Ulcer				
		policy identified the purpose of				
		to provide guidelines for the lentification of residents at risk				
		sure ulcers. The policy				
	indicated pressure	ulcers were usually formed				
		mained in the same position				
		eriod of time causing increased ease of circulation (blood flow)				
		destroys the tissues. If				
	•	ere not treated when				
		ave the potential to become infected. Pressure ulcers are a				
		ion for the resident. Staff were				
		and document the condition of				
		per facility wound and skin				
		signs and symptoms of own. Staff were to immediately				
		a developing pressure ulcer to				
	the supervisor. Sta	ff were to perform routine skin				
		ally care. Nurses were to be				
		the skin if skin changes are were to conduct skin				
		ast weekly to identify changes.				
	Because a residen	t at risk can develop a				
		nin 2 to 6 hours of the onset of				

Minnesota Department of Health

STATE FORM 6899 GT4K11 If continuation sheet 13 of 31

PRINTED: 10/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 Continued From page 13 2 900 pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. Additionally, the guidance indicated the following information was to be recorded in the resident's medical record utilizing facility forms: 1) The type of assessment conducted. 2) The date and time and type of skin care provided, if appropriate. 3) The name and title (or initials) of the individual who conducted the assessment. 4) Any change in the resident's condition. if identified tied. 5) The condition of the resident's skin like the size and location of any red or tender areas, if identified. 6) How the resident tolerated the procedure or his/her ability to participate in the procedure. 7) Any problems or complaints made by the resident related to the procedure or observations of anything unusual exhibited by the resident. 8) The signature and title (or initials) of the person recording the data. 9) Documentation in medical record addressing MD notification if new skin alteration noted with change of plan of care if indicated. 10) Documentation addressing family, guardian or resident notification if new skin alteration is noted with change of the care plan if indicated. Staff were to report other information in accordance with facility policy and professional standards of practice, notification of attending MD of skin concern, and notification should occur to

Minnesota Department of Health

the family, quardian or resident. While performing an assessment, if a new skin alteration was noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin, then staff

interventions individualized for the resident and their particular risk factors and document the

were to proceed to care planning and

STATE FORM 6899 GT4K11 If continuation sheet 14 of 31

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED		
ANDILAN	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		A	
4		00731	B. WING	<del></del>	09/2	; 2/202 <u>0</u>
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 14	2 900			
	procedure.					
		de to contact the facility's r comment without success.				
	The director of nurs all residents at risk they are receiving t treatment/services	to prevent pressure ulcers				
	pressure ulcers. The designee, could condelivery of care to each of the designer of the designer.	nd to promote healing of the director of nursing or nduct random audits of the ensure appropriate care and mented to reduce the risk for elopment.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21980	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 3 Reporting - Inerable Adults	21980			10/27/20
	reporter who has revulnerable adult is or who has knowled has sustained a phreasonably explaininformation to the cindividual is a vulne the individual is adureporter is not requi	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated irred to report suspected e individual that occurred prior ss:				
	another facility and	as admitted to the facility from the reporter has reason to ble adult was maltreated in the				

6899

Minnesota Department of Health STATE FORM

PRINTED: 10/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21980 Continued From page 15 21980 previous facility; or (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). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (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. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (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.

Minnesota Department of Health

This MN Requirement is not met as evidenced

Based on observation, interview and document

later than 2 hours, for 1 of 1 resident (R1) to the

State Agency and local police.

review, the facility failed to ensure an allegation of sexual assault was reported immediately but no

STATE FORM 6899 GT4K11 If continuation sheet 16 of 31

R1 had a risk management incident created 9-8-20. The MD was notified on

Her vulnerable adult care plan was

reviewed and updated and her

9-9-20, the Police were called on 9-15-20.

PRINTED: 10/30/2020

Minnesota Department of Health					FUNIVI AFFNUVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_D		00731	B. WING		C <b>09/22/202<u>0</u></b>	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY V	IEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
21980	Continued From pa	age 16	21980			
	Agency identified the report identifying the was notified on 9/4 by licensed practice advised staff she heroom. R1 alleged Legal had come into R1's hours and picked the floor. LPN-A advised under the nasal cand was from the condoxygen (O2). LPN-R1 was laying in be along her bottom". Was going to check action taken by factation taken b	20 report filed to the State he social worker (SW) filed a he director of nursing (DON) /20 of inappropriate touching all nurse (LPN)-A to R1. R1 had not wanted LPN-A in her LPN-A, at an unknown date, as room during the overnight up R1's nasal cannula off the ed R1 there was fluid directly nnula. R1 advised LPN-A it ensation from humidified A picked up R1's bedding as ed, and "moved his hands LPN-A had not advised R1 he as her for alleged incontinence. Ellity was identified as the DON to go into R1's room unless staff person present. LPN-A rereport on 9/8/20 pending an		preferences were reviewed and incoming and updated. Social Services metron 9-8-20, 9-9-20 and 9-10-20. MD contacted to review resident requesternal foley catheter. R1 was discon 9-22-20.  All residents vulnerable adult care and preferences were reviewed an updated as needed.  The Administrator and DON were in-serviced on abuse reporting, how make a report in the SA portal, keer resident complaints anonymous an suspension of employee/s upon sure of an allegation. The Administrator Director of Nursing, ADON and Society Service Director all have access to reporting platform and will be responsed in the service of the	with R1 D was st for charged  plans d  w to eping nd aspicion r, cial the possible 24/7.	
	investigation. There had reported the all Review of the facility began on 9/8/20 per R1 advised (RN-A) does not want a major time) stated he open. Over a week at the nurse aide on common. LPN-A stated he R1 what she need water. LPN-A went return, noted a purchard in the state of the purchard and the state of the purchard and the purchard gave R1 he	e was no mention the facility llegation to local police.  Ity's investigation notes, which er the social worker, identified on 9/4/20 at 10:10 p.m. she ale care giver. LPN-A (no date came to work on 9/4/20 at 8:00 ago (unsure of date and time), duty that night of the incident, nad reportedly put her call light be answered it. LPN-A asked ed. R1 stated she wanted cold to retrieve the water and upon addle or urine on the floor.  It water and was trying to figure from. He lifted R1's cover		An on-call schedule was implemen 9-28-20 on who to report to with Ar Allegation of abuse and posted at a nurses station by the phone. This schedule will be updated weekly.  Full time facility staff were in-servic 9-15-20 and 9-16-20 on the facility for reporting abuse with the emphareporting incidents immediately. A Staff meeting will be held on 10-26 review the facility abuse policy with emphasis on when Law Enforcement Primary Provider, Ombudsman and guardian will be notified.	each  eed on policy asis of n All -20 to ent, MD,	

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		00731	B. WING		09/22/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	~\ L_
			NINTH AVE		
VALLEY	VIEW MANOR HCC		TON, MN 56		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
21980	Continued From pa	age 17	21980		
21980	slightly to check he was trying to figure from. LPN-A patted on her face". LPN-down and cleaned identified R1 freque and voids in her be contact". We (facili caregivers. If he (L medication or atter male nurses will ta them into the room suspension on 9/8/ Further investigation remarked when he floor, he and LPN-left the room. On 9 interviewed by the identified R1 was consince she felt uncowhen the incident coccurred, but it was entered her room on asal cannula and LPN-A it was wet fit to get new tubing. It is get new tubi	er bed. LPN-A advised R1 he out where the urine came of the bed. R1 had a "funny look A immediately put the covers up the floor. The notes ently refused to be changed ed. "there was no inappropriate ty staff) will care plan "no male PN-A) needs to give not to medical tx [treatment], ke another female staff with ". LPN-A was notified of his		New employees will receive abuse ducation during their orientation and will continue annually.  Audits on reporting abuse allegatimely, facility notification posting staff for reporting will begin 2x wweeks, weekly x3 weeks then myear. Audits will be taken to QAP Administrator monthly x3 months oversight and to ensure compliant Responsible Party: Director of N Designee	tions y of on-call eek for 2 onthly x1 Pl by s for nce.
	outside smoking, c	e night of 9/4/20, R1 was ame inside and was visibly ed if she was ok to which R1			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

00731

B. WING \_

C 09/22/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: \_

#### **VALLEY VIEW MANOR HCC**

## **200 EAST NINTH AVENUE**

VALLET	VIEW MANOR HCC	LAMBERTON, MN	N 56152	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM.	FULL PREF	FIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE DATE
21980	Continued From page 18	21980	0	
	replied "Not really. Seeing [LPN-A] make nervous". Both NA's took R1 to her roor reported she had woken up to LPN-A clear brief by sticking his finger in the back brief without telling her. R1 denied she wet. After talking to RN-A, NA-A and NA advised LPN-A was not allowed in R1's Other staff were interviewed, but had no knowledge of the incident. Other reside interviewed for safety and had no issue concerns with staff. The Ombudsman worth notified on 9/8/20 and the medical direct identified as being notified on 9/9/20. It indicated in the report, after review of in the facility identified "it was our belief LI not abusive, nor had intent of abuse. Whe failed at communication". Corrective identified were male staff were to be accompanied by a female staff per residentified were male staff per residentified what he is doing before hand. was to have one-on-one supervision for RN-A was to be inserviced on 9/14/20 comportance of getting all the facts first hereporting timely. The facility was to mor corrective actions. There was no mention management had identified they failed the suspicion of a crime to the SA and I enforcement within 2 hours of the allegation of the sassessment identified she was for cognitive and required extensive assist for toileting.  R1's 8/18/20, progress notes identified admitted to the facility to receive rehabing services related to back pain and weak had pans to return home. Her admitting	m. R1 necking sk of her nad been A-B were room. o nts were s or vas tor was was terviews, PN-A was e believed e action  dent A would aining to LPN-A of 1 week. on the and and aitor its on facility o report aw ation.  Set ully of 1 staff  R1 was litative ness and		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 19 of 31 GT4K11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		L COM		(X3) DATE : COMPL		
AND FLAN	OF CORNECTION	IDENTIFICATION NOWIBER.	A. BUILDING:			
00731			B. WING		09/2	; 2/202 <u>0</u>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21980	Continued From pa	age 19	21980			
		w back pain, muscle cobstructive pulmonary disease				
	Interview on 9/14/2 above incident occ knowledge. LPN-A of the incident. R1 approximately 3:00 tubing and it was lathe end of her bed room to get R1 new proceeded to hook laying in bed on he from her door. R1 advised her he was underneath her O2 falling into the liquit to clean it up. R1 with the point". LPN-A incontinence pad. not advised R1 whorief. LPN-A asked to help her clean ustated he made a heleft the room. Richard he made a heleft the room. Richard he was drycares. In hindsight clear during cares (RN)-A had advise R1's room at any thad touched R1 in to call the DON and the staff members.	20, with LPN-A identified the curred about a week ago to his a was charge nurse on the night had put her call light on at 0 a.m R1 had lost her oxygen aying on the floor in a puddle at by R1's feet. LPN-A left the w O2 tubing. LPN-A then a up R1's new tubing. R1 was er side, facing the wall, away had a fluffy blanket. LPN-A is cleaning up the liquid fond 2 tubing. R1's blanket kept id on the floor as he was trying was "uncomfortable with me at proceeded to touch R1's LPN-A acknowledged he had at he was going to check her id R1 if she wanted another staff up, but she refused. LPN-A then "joke" to which R1 laughed and it had never made concerns ecciving assistance from male N-A was unsure how R1 could by the foot of her bed, when allow her bottom, in the middle of N-A had been known to refuse the should have been "more is. On 9/4/20, registered nurse in the middle in he was not to go into ime. RN-A advised LPN-A he appropriately. RN-A was going dialert her to R1's allegations. ack and spoke with LPN-A. He				
	was told to keep h	is distance from R1 and have ber give R1 her medications.				

Minnesota Department of Health

STATE FORM 6899 GT4K11 If continuation sheet 20 of 31

PRINTED: 10/30/2020

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21980 Continued From page 20 21980 He was suspended on 9/8/20 pending an investigation. He had worked 9/4/20, 9/5/20, and 9/6/20. LPN-A had come to the facility on 9/14/20 as he was turning in his resignation effective 9/19/20. He was to work his upcoming 3 scheduled shifts on 9/17/20 through 9/19/20. LPN-A was resigning over the allegations. Review of LPN-A's August and September, 2020. staff schedules and time clock entries identified LPN-A was scheduled to work overnight shifts on 8/27/20, 8/31/20, 9/3/20, 9/4/20, 9/5/20, and 9/6/20.. LPN-A's timecard identified he worked on: 1) 8/27/20, beginning at 6:00 p.m. until 6:46 a.m. 2) 8/31/20, beginning at 9:58 p.m. until 6:51 a.m. 3) 9/3/20, beginning at 10:01 p.m. until 6:40 a.m. 4) 9/4/20, beginning at 8:03 p.m. until 6:46 a.m. 5) 9/5/20, beginning at 6:02 p.m. through 6:28 a.m., 6) 9/6/20 beginning at 5:58 p.m. and finishing at 7:09 a.m. Review of LPN-A's employee file identified a performance review dated 9/14/20, 3 resident complaints were identified on 5/5/20, 6/22/20, and 9/4/20. The review identified LPN-A was flexible, worked both units and preferred working his night shift. LPN-A was identified having conflicts with some residents. LPN-A was to watch his tone as he had made "hurtful" statements without realizing it. It was identified he needed to "explain what you are doing, before you do it." LPN-A had a background check performed 6/3/20, which identified LPN-A had no criminal history reported.

Minnesota Department of Health

LPN-A was hired 11/18/19. There was no previous background check identified in his file. LPN-A had concern and problem resolution coaching's in his file. With regard to R3's complaint of LPN-A looking at her vagina, it was

STATE FORM 6899 If continuation sheet 21 of 31 GT4K11

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### 200 EAST NINTH AVENUE

#### VALLEY VIEW MANOR HCC

VALLEY	VIEW MANOR HCC	LAMBERTO	ON, MN 561	152	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 21		21980		
	identified by the facility LPN-A had to old people, its all in your head and you things." R3 reported to management "skin crawl" and was rude when other weren't around. He told her in a "cree I'm back" when he returned to work disciplinary actions were included in Interview on 9/14/20 with nursing assidentified she was made aware of the 9/4/20 by R1. R1 had reported to NA she had seen LPN-A report for his stated approximately 8:00 p.m R1 was noted R1 was afraid to come in and R1 stated "I don't want that [expletive with me. R1 elaborated LPN-A had runcomfortable the last time he work came into her room during the incided date) and started "poking" at her both wears an incontinence brief. R1 state was touching her inappropriately and know what to say to LPN-A at that tire advised she was shocked and scare told anyone about the incident before she was afraid. R1 began to cry and into any further detail with NA-A or NNA-A and NA-B left R1's room and immediately. RN-A went into R1's room and looked to be visibly upset allegations R1 had advised her of. R witnessed telling LPN-A he was not a R1's room. R1 had never had any comale staff. There was another male floor and R1 had no concerns with the member.  Interview on 9/14/20 at 4:41 p.m. with the member.	bu imagine the made her er staff epy voice the No LPN-A's file.  Sistant (NA)-A e incident on the A and NA-B nift that day outside. Staff was shaking. e] working nade he feel ed. LPN-A ent (unknown tom. R1 ed LPN-A d did not me. R1 d. R1 had not e 9/4/20, and would not go lA-B. Both advised RN-A om and A exited the by the N-A was to go into oncerns with staff on the nat male staff			
	identified R1 was a smoker and was evening of 9/4/20. LPN-A had come	outside the			

Minnesota Department of Health

STATE FORM 6899 GT4K11 If continuation sheet 22 of 31

PRINTED: 10/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21980 Continued From page 22 21980 around 8:00 p.m. that day for his shift. NA-A and NA-B had noticed R1 was outside and rang the doorbell to come back into the facility. R1 was shaking and visibly upset. "She was petrified". NA-A and NA-B proceeded to ask R1 what the matter was. She was reluctant to sav. R1 proceeded to tell the staff LPN-A had come into her room the other might when he worked. R1 advised LPN-A was checking her to see if she was wet. He stuck his fingers in her brief and touched her inappropriately. R1 takes care of herself and requires no assistance to toilet or put herself to bed etc. She only needed help when she was first admitted. R1 was expected to discharge soon. NA- A and NA-B left to find RN-A and advise her of the need to speak with R1 as soon as possible. RN-A was giving meds, and as soon as she was done, she would speak with R1. RN-A finished her medication pass and went to speak with R1 in her room. When RN-A came out of R1's room, she went to LPN-A who was working on that wing and advised him he was not to go into R1's room. Today on 9/14/20, when LPN-A came to work, R1 saw him come in. She began shaking. R1 kept watching the door to see if LPN-A was coming onto shift. Observation and interview on 9/14/20 at 5:00 p.m., with R1 identified LPN-A works overnight shifts. R1 goes to bed early. On the date of the incident which R1 recalled as the last time he worked but was unsure of that date. R 1 stated

Minnesota Department of Health

LPN-A usually works weekends. It would have been the previous weekend night shifts to 9/4/20. R1 is awake and routinely sees the night shift report to work. R1 pointed to her calendar and identified the incident likely occurred between the dates of 8/28/20 and 8/31/20 which was the last scheduled weekend she saw him. LPN-A came into R1's room. She was sound asleep but woke

STATE FORM 6899 GT4K11 If continuation sheet 23 of 31

<u> </u>	<u>ita Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	LETED
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		00731	B. WING			, 2/2020
		00731			09/2	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HOC	200 EAST	NINTH AVE	NUE		
VALLEY	VIEW MANOR HCC	LAMBER <sup>*</sup>	TON, MN 56	152		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
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				DEI IGIENOT)		
21980	Continued From pa	age 23	21980			
	up startlad when al	e realized D1 was in her				
		ne realized R1 was in her at night. Occasionally this falls				
		laying on the floor at the foot				
		picked up the tubing, gave it to				
		d him it was wet. LPN_A stated				
		oor where her tubing had been.				
		ed wet the tubing, left the room,				
		h new O2 tubing. LPN-A				
		ot of liquid on the floor at her				
		e". R1 advised him that was				
		her O2 tubing with humidified				
		she had not felt wet in her				
		ed her the rag after he wiped				
		floor and showed her it was				
		the over-bed lights on at all				
	times and would la	y on hr left side with her back				
	away from the doo	r, facing the wall. All of a				
		covers being lifted and LPN-A				
		ers on her [expletive]. R1				
		rified". LPN-A had not said				
		start feeling her bottom, then				
		cking noises but was unsure				
		ning from. She thought it				
		light nurses use, but never				
		tht of any kind. R1 denied				
		ated her in any way. "His finger				
		ng up and down." R1 stated				
		n touched like that before.				
		ching her brief. R1 toilets				
	nerself and had no	reason for LPN-A to attempt				

Minnesota Department of Health

to check her brief for wetness. R1 identified she was "so scared" and "hadn ' t had the nerve to talk". LPN-A finally said "Do you need to be

changed?". R1 was able to say "No". LPN-A replied to her "Alright then" and left her room. R1 stated LPN-A was very intentionally touching her buttocks and was not in any way on her brief. No staff had ever touched her that way before. R1 has never had any concerns with any male staff at any health facility. R1 elaborated the wet spot

STATE FORM 6899 If continuation sheet 24 of 31 GT4K11

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE	SURVEY	
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		00731	B. WING		09/2	2 <b>2/2020</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21980	on the floor was by directly below her be night and again tood LPN-A arrive for wo coming back to work LPN-A today arrive and got a "creepy" nausea. R1 does not at lak! Others [rehome soon and wa Observations during was visibly shaken anger throughout the Interview on 9/14/2 identified she was rof sexual abuse fro RN-A stated NA-A advised her they we R1 was shaking. Rand the staff wante requested RN-A spand NA-B she would passed her medicat up again. RN-A was medication pass, and RN-A had never medication pass, and RN-A had never medication pass and the staff medication pass, and the staff medication pass, and RN-A had never medication pass.	her feet, not on the floor bottom. R1 was scared that lay on 9/14/20, when she saw brk. R1 was afraid LPN-A was rk. R1 stated when she saw for work, she started shaking, feeling in her stomach with ot feel safe around LPN-A. "I esidents] can't". R1 was going lked independently with cares. g interview of R1 identified was teary eyed and expressed				

Minnesota Department of Health
STATE FORM

PRINTED: 10/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21980 Continued From page 25 21980 RN-A asked her what she would like her to do about him. R1 said he wiped a spot by the bathroom door towards edge of bed. R1 denied being wet. R1 denied penetration, and stated he just left. RN-A assured R1 her concerns would be forwarded. R1 also advised RN-A she had been molested as a child and it felt "just like that". RN-A had not included that in her written report as R1 seemed embarrassed about her past molestation. RN-A had not performed an assessment or started an investigation. RN-A stated she called the DON right away for instruction on how to proceed. The DON had advised RN-A to write a report and see if there was nay further information R1 had on the allegations. The DON had not suspended LPN-A to her knowledge. The DON had called back to the facility after she had spoken with her, but she had not talked to RN-A. The DON spoke to LPN-A. RN-A had never been educated on filing a report to the SA, nor reporting a suspicion of a crime to the police, RN-A looks for direction from the DON and does what she is told. Since RN-A was an occasional staff person and had not worked for a while prior to 9/4/20. Upon arriving to work that day, she was handed the policy on reporting, advised to read through it and ask if she had questions. RN-A had made no attempt to physically examine R1 on 9/4/20 after allegations of sexual abuse had been made.

Minnesota Department of Health

Review of the 9/4/20, incident report written by RN-A identified R1 advised NA-A and NA-B, she did not want LPN-A in her room. Staff asked RN-A to speak with her. R1 advised RN-a LPN-A was inappropriately touching her one time but was unable to give a date. LPN-A had come into her room. R1 was unsure why LPN-A had entered her room. R1's nasal cannula had come off and was on the floor. LPN-A picked it and it was wet.

STATE FORM 6899 GT4K11 If continuation sheet 26 of 31

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
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00731			B. WING		09/2	) 2 <b>2/202<u>0</u></b>
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW MANOR HCC		NINTH AVE FON, MN 56			
(Y4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN (	OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETE DATE
21980	Continued From pa	ge 26	21980			
21980	R1 advised she felt (from humidified ox her bedspread and her "butt". LPN-A ha was doing. She req Interview and docur a.m., with the SW is to the facility on 9/4 of the incident. On work and saw RN-A immediately went to advised her this wa review of the staffin 9/4/20, it was identishifts were 9/3/20 a not have seen LPN 9/3/20, as she woul incident was reported shift time-frame he SW agreed the incilikely occurred on 8 of the investigation, had plans to submit that day. The SW c the allegation likely corroborate there w LPN-A advised her indeed at the end of directly below where "definitely upset abdensure LPN-A had was visibly upset, n reported when she The SW believed, "should have told he	it was wet from condensation (ygen). LPN-A had picked up started moving his hand along ad not advised R1 what he quested he not enter her room.  Interview on 9/15/20 at 9:43 dentified the DON never came 1/20, after being made aware 9/8/20, the SW arrived for A's written report. She to the administrator (A) and as a reportable incident. In the schedule leading up to ified LPN-A's last scheduled and 8/31/20. LPN-A. R1 would 1-A arrive for that shift on a lid have been in bed, and the led to occur the last weekend worked before 9/4/20. The ledent would have most have 1/31/20. The SW was in charge 1/31/20. The SW was in charge 1/31/20. The SW could not 1/31/20. The SW could not 1/31/20 actual urine on the floor. The location of the urine was 1/31/20 fithe bed by R1's feet and not 1/32 eher bottom was. R1 was 1/32 out it". The facility wanted to 1/32 not crying, but anxious SW 1/34 recalled her interview with R1. 1/34 what went wrong was he 1/34 was 1/34 he was doing". In				
	floor, the SW agree	on of the fluid found on the ed, there was no way R1's				
		eposited at the foot of her bed, below her bottom located in				

Minnesota Department of Health STATE FORM

FORM 6899 GT4K11 If continuation sheet 27 of 31

(X3) DATE SURVEY COMPLETED

00731

B. WING \_

C **09/22/2020** 

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### **VALLEY VIEW MANOR HCC**

### 200 EAST NINTH AVENUE LAMBERTON. MN 56152

VALLEY	VIEW MANOR HCC	TON, MN 561		
(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) COMPLETE DATE
21980	Continued From page 27	21980		
	the middle of the bed, approximately over 2 feet away. The SW identified the only staff that were allowed to make reports the to SA were herself, the DON and administrator. She also agreed R1 wearing a brief would have limited deposits of urine on the floor and would have saturated R1's bed first. She agreed R1 made no mention of her bedding being wet. R1 also claimed LPN-A had not touched her brief, but was touching her buttocks. The SW agreed, R1's accounts her buttocks was being stroked by LPN-A's fingers would be inconsistent if her underwear were pulled away from her body to feel a brief. The SW also agreed R1 had been independent to toilet and there was no need to physically check her for incontinence. The SW agreed the DON should have immediately suspended LPN-A upon hearing the allegation and reported to the SA. Facility procedures indicated only the SW, admin or the DON could submit a report to the SA. No other staff were allowed to submit reports of suspicions of a crime.			
	Interview on 9/15/20 at 10:20 a.m. with nurse practitioner (NP)-A identified she was unaware of R1's allegation of sexual abuse. The SW had called her, only to ask for the medical director (MD) number last wed. She was on call on 9/4/20 covering nights and weekends. NP-A rounded at the facility on 9/8/20, and was not notified about the allegations at that time either. She would expect the facility follow all policies and procedures and notify a residents provider when any allegation of abuse or neglect is made. NP-A was made aware of the interviews and events surrounding the allegations. NP-A expected the facility keep the resident safe and suspend any staff until an investigation was completed. R1 had improved in the ability to care for herself and could walk independently, toilet independently,			

Minnesota Department of Health

STATE FORM 6899 GT4K11 If continuation sheet 28 of 31

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING: (X3) DATE SU COMPLET		
	A. BOILDING.			
00731	B. WING			22/ <b>2020</b>
STREET AD	DRESS CITY S	STATE ZIP CODE		
EMENT OF DEFICIENCIES	ID			(X5)
JUST BE PRECEDED BY FULL DESCRIPTION (USE INFORMATION)	PREFIX TAG	CROSS-REFERENCI	ED TO THE APPROPRIATE	COMPLETE DATE
e 28	21980			
nd was set to go home in the				
at 10:53 a.m., with the DON ceived a call on 9/4/20 at p.m., RN-A had called her ed to file a complaint against ted RN-A offered no other nad not asked. The DON out what prompted such a her back. After nutes, the DON called the red the phone. The DON anything inappropriate" as R1 plaint against him. LPN_A ng, but did advise the DON stion and stated he had and advised her. The reason he had done done anything had been accused by R3 of with allegations "He looked ON had filed a report but felt was unsubstantiated as viding personal cares and at R3's private parts. The knowingly disclosed the dentity to LPN-A. The DON N-A's answer of no ed he was not allowed to unless he was accompanied DON agreed, advising victims identity and not ling LPN-A placed R1 and of for further abuse or failed to begin an ately and had not returned to 0. At that time, she was the facilities investigation.				
AC TERMINATED TERMINATED TO THE TOTAL TOTA	200 EAST LAMBERT  MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)  228  and was set to go home in the  at 10:53 a.m., with the DON seived a call on 9/4/20 at p.m., RN-A had called her and to file a complaint against ted RN-A offered no other had not asked. The DON out what prompted such a her back. After sutes, the DON called the red the phone. The DON unything inappropriate" as R1 laint against him. LPN_A had, but did advise the DON stion and stated he had and advised her. The reason he had done done anything had been accused by R3 of with allegations "He looked ON had filed a report but felt was unsubstantiated as riding personal cares and hat R3's private parts. The knowingly disclosed the dentity to LPN-A. The DON N-A's answer of no had he was not allowed to halless he was accompanied DON agreed, advising victims identity and not ing LPN-A placed R1 and had for further abuse or failed to begin an hately and had not returned to hat that time, she was he facilities investigation.	STREET ADDRESS, CITY, S  200 EAST NINTH AVE LAMBERTON, MN 56  MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)  228  21980  219	STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE LAMBERTON, MN 56152  MENT OF DEFICIENCIES (IDENTIFYING INFORMATION)  At 10:53 a.m., with the DON relived a call on 9/4/20 at p.m., RN-A had called her ed to file a complaint against ted RN-A offered no other rad not asked. The DON ruything inappropriate" as R1 laint against him. LPN_A rig, but did advise the DON stion and stated he had rad done done anything and been accused by R3 of with allegations "He looked ON had filed a report but felt was unsubstantiated as riding personal cares and at R3's private parts. The knowingly disclosed the dentity to LPN-A. The DON ruyths answer of no rid he was not allowed to riless he was accompanied DON agreed, advising victims identity and not ing LPN-A placed R1 and to At that time, she was the facilities investigation.	STREET ADDRESS, CITY, STATE, ZIP CODE  200 EAST NINTH AVENUE  LAMBERTON, MN 56152  MENT OF DEFICIENCIES UST BE PRECEDED BY FULL (DENTIFYING INFORMATION)  PREPIX TAG  228  21980

Minnesota Department of Health STATE FORM

PRINTED: 10/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21980 Continued From page 29 21980 prevent abuse and failing to follow facility policy put all residents at risk. Interview on 9/15/20 at 12:27 p.m. with the MD identified he had not been made aware of the incident until approximately 9/8/20. He was told by the facility R1 reported LPN-A felt her bottom, maybe she had not liked that and was found very upset. MD had not known "much more". MD was unaware LPN-A was notified of R1's identity by the DON, nor that LPN-A had not been suspended immediately, or that no investigation was immediately performed upon identifying the allegation. The MD agreed the facility failed to keep R1 and all other 44 residents safe from retaliation or potential further abuse. He also agreed LPN-A should have been suspended, policies implemented, and an investigation should have been immediately started. Interview on 9/15/20 at 2:45 p.m. with the SW identified she had not called local police for suspicion of a crime but would do so right away. The SW had reported the incident to the MN Board of Nursing. Review of the 9/4/20, Reporting Abuse to Facility Management policy identified it was the responsibility of employees, consultants, physicians, family members, visitors, etc, to promptly report any incident of suspected abuse. All allegations were to be reported and thoroughly

Minnesota Department of Health

investigated. All reports made were to be made without fear or retaliation from facility or its staff. Reports were to be given to the DON. In her absence, reports were to be made the the charge nurse. Staff members shall not knowingly fail to report an incident or offense, screen reports, or withhold information from reporting agencies. If incidents were discovered after hours (8:00 a.m.

STATE FORM 6899 GT4K11 If continuation sheet 30 of 31

PRINTED: 10/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00731 09/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE **VALLEY VIEW MANOR HCC** LAMBERTON, MN 56152 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21980 Continued From page 30 21980 to 5:00 p.m.), the admin or DON must be called at home and informed of the incident. Allegations were to be reported immediately but no later than 2 hours after the allegation was made. Employees accused of abuse were to be suspended immediately pending the outcome of the investigation. For reports of physical or sexual abuse, a thorough examination was to be performed by licensed nurses. An immediate investigation was to be made and a copy provided to the administrator. Review of the 9/4/20, Abuse Investigations policy identified all reports of abuse were to be promptly reported and thoroughly investigated by the facility immediately but no later than 2 hrs after the allegation. The Ombudsman was to be notified and offered to participate in the investigation. The Ombudsman was to be notified of results of the investigation. Employees were to be suspended immediately. The administrator was to provide a written report of the results to the SA, local police. medical director and others within 5 days of the incident. There was no mention suspicions of a crime were to be reported immediately to local police, the SA, and any other licensing boards immediately but not later than 2 hours. There was also no mention investigations were to begin immediately following an accusation of abuse.

Minnesota Department of Health STATE FORM



Protecting, Maintaining and Improving the Health of All Minnesotans

November 3, 2020

Shirley Brekken, Executive Director Board of Nursing Park Plaza Building 2829 University Avenue Southeast, Suite 500 Minneapolis, Minnesota 55414

Dear Ms. Brekken:

This is relative to a full survey conducted at Valley View Manor HCC, 200 East Ninth Avenue, Lamberton, MN, 56152 and completed on September 22, 2020.

At the time of this survey it was determined that the residents in this facility have received substandard quality of care.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The director of nursing at the time of the survey was Shawna Dorr-Jones.

If you have any questions on this matter, please do not hesitate to call me.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fish Downing

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: kamala.fiske-downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

November 3, 2020

Randy Snyder, Executive Director Board of Nursing Home Administrators Park Plaza Building 2829 University Avenue Southeast, Suite 440 Minneapolis, Minnesota 55414

Dear Mr. Snyder:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the Board of Nursing Home Administrators whenever we determine that substandard quality of care has been provided to residents. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life, § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection Control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

Based on our survey of Valley View Manor HCC, 200 East Ninth Avenue, Lamberton, MN, 56152, which was completed on September 22, 2020, we have determined that substandard quality of care was provided. Listed below are the federal violations that led to this determination.

F600 -- S/S: K -- 483.12(a)(1) -- Free From Abuse And Neglect; F686 -- S/S: J -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer

Freedom from Abuse, Neglect, and Exploitation (§ 483.12). Regulations in this area grant residents the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. 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.

Quality of Care (§ 483.25). Regulations in this area grant residents the right to receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status.

Copies of the deficiencies with a plan of correction from this survey and the previous survey are enclosed. The administrator is Ms. Dawn Giese.

If you have any questions, please feel free to contact me.

Sincerely,

Valley View Manor Hcc November 3, 2020 Page 2

Kamala Fiske-Downing

Minnesota Department of Health

Kamala Fiske Downing

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: <a href="mailto:kamala.fiske-downing@state.mn.us">kamala.fiske-downing@state.mn.us</a>



Protecting, Maintaining and Improving the Health of All Minnesotans

October 13, 2020

Dr. Julie Kircher Carris Health - Redwood Clinic 1100 E. Broadway Redwood Falls, MN 56283

Dear Dr. Kircher:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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Quality of Care (§ 483.25). Regulations in this area grant residents the right to receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status.

The above facility has prepared a plan to correct the deficiencies which we found during the survey. You can assist by discussing the survey findings with the facility's medical director. Copies of the survey findings which provide detailed information on the violations can be reviewed at the facility.

If you have any questions, please feel free to contact me.

Valley View Manor HCC October 13, 2020 Page 2

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kamala Fishe Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

October 13, 2020

Dr. Annette Schmit-Cline New Ulm Medical Center 1324 Fifth North Street New Ulm, MN 56073

Dear Dr. Schmit-Cline:

The Minnesota Department of Health - Health Regulation Division is the state agency charged with the responsibility of inspecting skilled nursing facilities and nursing facilities in the state. Federal regulation requires us to notify the attending physicians of nursing home residents who have received substandard quality of care. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under § 483.10 Residents Rights, § 483.12 Freedom from Abuse, Neglect, and Exploitation, § 483.24 Quality of Life § 483.25 Quality of Care, § 483.40 Behavioral Health Services, § 483.45 Pharmacy Services, § 483.70 Administration, or § 483.80 Infection control, which constitutes either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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If you have any questions, please feel free to contact me.

Valley View Manor HCC October 13, 2020 Page 2

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

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