Electronically delivered
February 1, 2022

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

RE: CCN: 245378
Cycle Start Date: January 19, 2022

Dear Administrator:

On January 19, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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, Minnesota 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 19, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 19, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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
Minnesota Department of Health
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING _____ B. WING _____	C 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	**200 EAST NINTH AVENUE LAMBERTON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/18/22 through 1/19/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5378037C (MN61680), however NO deficiencies were cited due to actions taken by the facility prior to the survey. The following complaint was found to be UNSUBSTANTIATED: H5378031C (MN76300), however, related deficiency was cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5378032C (MN72611) (MN65402), (MN69873) (MN70268), H5378033C (MN72368), H5378034C (MN72132), H5378035C (MN64576), and H5378036C (MN61682). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/04/2022

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

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F 689	Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R6) was appropriately supervised and prohibited from keeping a cigarette lighter on his person in accordance with the National Fire Protection (NFPA) 101, the Life Safety Code at 19.7.4, when R6 was caught by staff smoking in a restricted area. Findings include: Review of the 2012, NFPA 101, Life Safety Code at 19.7.4, identified smoking regulations were to be adopted and shall include at a minimum whereas smoking is to be prohibited in any ward, room or enclosed space or hazardous location. Smoking by residents classified as not responsible is to be prohibited unless under direct supervision. R6 was admitted to the facility in June 2021 with diagnoses of altered mental status, stroke, and dementia. R6's 9/1/21 at 3:41 p.m., physician progress note documented by nurse practitioner (NP)-A identified staff notified NP-A that R1 had eloped from the facility. NP-A ordered R6 to have a WanderGuard placed. R6 was a smoker. NP-A recommended supervised smoking as she felt R6	F 689	R 6 had a new smoking assessment completed, a smoking care plan created and his lighter removed from his person and smoking times established. All other residents who smoke were reviewed for smoking safety and their care plans were reviewed and updated as needed. Future residents will be assessed for smoking upon admission, quarterly and as needed. Facility staff were in-serviced on the Smoking Policy Residents with emphasis on items 8, 9, and 10 that smoking privileges can be imposed at any time if a resident is deemed unsafe to smoke. The smoking policy will be reviewed at the next resident council tentatively scheduled for 02/09/2022. Residents who smoke will obtain lighters from the nurse and return them when they are done. Social Services and/or designee is responsible for compliance. Audits on resident smoking and compliance will begin 2x week for 2 weeks then monthly to ensure compliance. Audits will be reviewed by the Administrator then taken to QAPI for review and further recommendation. Compliance: 2/11/2022	

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would become irritable without smoking.

R6's progress notes identified on:
1) 9/1/21 at 3:00 p.m., staff requested the NP give an order for a WanderGuard to be placed.
2) 9/1/21 at 6:00 p.m., staff documented they received the above-mentioned physician progress note from NP-A. There was no mention staff identified R6 to be supervised while smoking.
3) 9/1/21 at 8:10 p.m., staff documented her refused medications but "Did comply with rules so was able to go out and smoke at [6:50 p.m.]".
4) 9/6/21 at 1:21 p.m., staff noted R6 had called the Sheriff's office about the facility stealing his cigarettes. R6 was upset about not being able to have more than 4 per day and advised police someone was "stealing them".
5) 9/6/21 at 4:03 p.m., R6 was upset he was not allowed out of the building unsupervised to walk to the store to purchase cigarettes.
6) 9/7/21 at 7:46 a.m., R6 was upset about not having enough cigarettes to smoke. The nurse sat outside with R6 while he smoked at that time. Staff were to address smoking times and interventions with management.
7) 9/7/21 at 1:49 p.m., staff noted R6 was to be allowed to smoke 2 cigarettes at a time when he was to be supervised while smoking.
8) 9/15/21 at 5:45 p.m., R6 was seen in another resident's room who also smoked and would leave his smoking supplies lay out in his room. Staff noticed R6 put something into the storage of his 4 wheeled walker but had not seen what it was, nor did that staff investigate to see if R6 had taken the smoking materials left unsecured in an unidentified resident's room.
9) 9/19/21, R1 attempted to prop the front door open after another resident went outside to smoke. R6 reported he was "going to sneak out

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to smoke" since no staff would take him. A few minutes later, R6 asked staff if the conference room windows opened. Staff told the charge nurse and R6 was found in the conference room trying to open windows. He stated, "I'm not smoking". There was no indication if staff ensured R6 did not have access to smoking materials as he was deemed unsafe to smoke without supervision.
10) 9/21/21, R6 had removed his WanderGuard.
11) 9/27/21, staff noted R6's cigarettes were kept in the medication room.
12) 10/3/21 at 3:08 p.m., R6 was noted to be outside unsupervised that morning. When staff asked R6 how he got outside, he stated he "snuck" out the door behind another resident.
13) 10/1/21 at 8:50 p.m., the social worker noted R6 "had his last pack of cigarettes".
14) 11/14/21, R6 refused to go to an appointment, Staff noted he had been outside smoking. There was no mention if R6 had been allowed to smoke once again or if he had been supervised.
15) 1/15/22 at 9:24 a.m., R6 was noted by staff to have gone into the basement without his walker, opened the outside door and was smoking cigarettes. Staff had heard the basement door close and went to investigate. Staff found snow inside the door and the corridor smelled heavily of smoke. When staff asked R6 what he was doing in the basement, he stated he was allowed to go down there to exercise. Staff advised him he was not allowed in that area without staff present. R6 became angry and asked staff "Who snitched on me!". Prior to the event, R6 was seen in the front of the facility with his coat on at 6:30 a.m., looking out the window. The was no mention staff had asked R6 why he had a coat on in the early morning hours or if they provided any extra supervision to prevent R6 from smoking in a

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restricted area of the building.
R6 was noted to have numerous behaviors of depression, refusal of cares, attempting to potentially acquire another residents' unsecured cigarettes, and angry outbursts when R6 had not been allowed to smoke or smoke as much as he wanted. There was no indication staff had identified the need for increased supervision, that R6 could smoke safely, or the need to secure smoking materials from other residents away from R6.

R6's 12/23/21, Smoking Review assessment identified R6 currently smoked, had no history of smoking related incidents, had no signs of confusion, was able to verbalize understanding of facility smoking policies, and understood where he could smoke. There was no mention staff had reviewed R6's diagnoses or progress notes to identify he had a history of dementia, numerous verbal outbursts and behaviors, had been seen searching out other residents' smoking materials left unsecured by other residents without the facility enforcing security of those items, or that R6 had attempted to potentially smoke out the conference window in September 2021.

Observation on 1/18/22 at 11:00 a.m., of the door to the basement area identified there was a green button located on the upper right side of the door frame. To release the door, the button had to be pushed at the same time the door handle was depressed. Inside the door, a long ramp extended down, with 2 turns before access to the basement floor. At the end, there were 2 doors exiting to the outside. The door opened onto a sidewalk that led to the apartment complex next door.

Observation on 1/19/22 at 9:00 a.m., R6 went

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outside without staff in attendance to smoke, following the main door code entered and opened by an unidentified staff member. R6 pulled his lighter out of his coat pocket in addition to his cigarette which he lit and walked about independently as he smoked..

Interview on 1/18/22 at 11:08 a.m., with registered nurse (RN)- C identified R6 smoked, He would go outside to the smoking designated area, with staff assistance only to exit the building. RN-C indicated R6 had possession of his own smoking materials which included cigarettes and a lighter. RN-C explained the facility limited smoking time to the hours of 6:00 a.m. until 9:00 p.m. as staff were not able to monitor residents outside after that time.

Interview on 1/18/22 at 11:21 a.m., with RN-B identified on 1/15/22 at approximately 7:00 a.m., RN-B was informed by trained medication aide (TMA)-A she heard the basement door slam. R6 was no longer in the hall waiting to go outside to smoke. She opened the basement door and called out R6's name. After a short time, R6 came from around the corner of the ramp and stated he had gone down the basement to "exercise on the ramp". R6 was informed he was not to be in the basement area without staff in attendance and voiced understanding. TMA-B went down the basement to investigate what R6 had been doing, and discovered the outside door had been opened, there was snow inside the door, and a strong smell of cigarette smoke lingered. TMA-B opened the door and saw footprints in the snow. RN-B spoke with R6 asking if he had been smoking in the basement. R6 denied this but then asked who had "snitched on him". RN-B identified maintenance was

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notified. Staff placed a sign on the door which read "Staff Only". A nightstand was placed in front of the door to prevent easy access until maintenance arrived to determine what needed to be done to prevent R6 from accessing the basement area.

Interview on 1/19/22 at 11:05 a.m., with trained medication aid (TMA)-C identified there were three residents in the facility who smoked, (R6, R7, and R8). All three residents were deemed able to smoke independently in the designated smoking area under the covered entrance to the building. R7 and R8 kept their own smoking materials, (identified as cigarettes and lighter). She recalled R6 used to have his materials stored in the medication room, but she was not certain if that was still the case or if R6 was allowed to carry smoking materials on his person.

Interview on 1/18/22 at 11:30 p.m., with the social services designee (SSD) identified she had spoken with R6 following the above incident in the basement. He had stated he used to walk on the ramp with therapy for exercise and that was why he was in the basement. R6 refused to admit he had been smoking and was again informed he could not access the ramp area without staff in attendance. A safety assessment was completed with the determination R6 was safe to smoke independently. The SSD identified a nursing assessment determined if a resident was able to keep their own smoking materials on their person or room. The SSD confirmed there were currently 3 residents in the building at the present time that smoked who had possession of their smoking materials, including R6. There was no indication by the SW, if she identified R6 had been unsafe to smoke unsupervised, was allowed to keep

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smoking materials on his person, or ensured if other residents who kept their own smoking materials in their rooms or on their person, had safely secured these items to ensure they were inaccessible to R6.

Interview on 1/18/22 at 12:22 p.m., with the interim director of nursing (IDON), identified R6 had a guardian appointed due to a history of poor decisions and safety concerns. R6 had a history of non-compliance with treatments, medications, and medical appointments. The IDON stated R6 had attempted to manipulate others to purchase items for him such as energy drinks and cigarettes. The facility investigation into R6's access to the basement area identified he was capable of watching how to access the area by staff and learned how to gain access himself. The incident had been discussed at IDT on 1/17/22. A decision was made to install a keypad lock to prevent unauthorized access to the basement. The IDON stated Maintenance was working on the installation of a keypad for limit unauthorized access to the area. She agreed there was a safety risk if a resident accessed the area or if a resident was smoking without staff supervision and/or knowledge who demonstrated a history of unsafe actions or decreased cognition. The IDON identified the smoking assessment identified if a resident was able to maintain his own smoking materials.

Interview on 1/18/22 at 2:47 p.m., with R6's provider (NP), identified he had a history of making poor decisions, and had a court appointed legal guardian. R6 had a previous history of an elopement when he left the facility and walked uptown and was returned by law enforcement. According to the resident he was

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F 689	Continued From page 8 looking for money to buy cigarettes. R6 was known to be non-compliant with his treatment plan, refused medications at times, and refused appointments. The NP stated R6 made poor decision choices. Interview on 1/18/22 at 3:15 p.m., with R6 identified he was able to describe how to open the door to access the basement because the previous physical therapist had shown him how to do it. He was aware he was not supposed to go down there, and now they had "changed the locks". Review of the 8/24/21, Smoking Policy for Residents identified residents that were assessed at the time of admission and quarterly for safety. Smoking materials for residents determined unsafe to smoke independently were not to be allowed to have possession of smoking materials. The materials were to be secured at the nursing station. There was no mention of the practice of storing smoking materials for those residents that were able to smoke independently or how the facility would ensure security of those smoking materials away from residents who were unsafe, or how appropriate supervision was to be maintained for residents at risk for or known to show unsafe smoking habits.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 1, 2022

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

Re: Event ID: QST711

Dear Administrator:

The above facility survey was completed on January 19, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00731	A. BUILDING: _____ B. WING _____	C 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/18/22 through 1/19/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5378037C (MN61680), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5378031C (MN76300), H5378032C (MN72611) (MN65402) (MN69873) (MN70268), H5378033C (MN72368), H5378034C (MN72132), H5378035C (MN64576), and H5378036C (MN61682). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		