Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2022

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

RE: CCN: 245378
Cycle Start Date: June 24, 2022

Dear Administrator:

On July 7, 2022, we notified you a remedy was imposed. On July 20, 2022 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 July 15, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2022 did not go into effect. (42 CFR 488.417 (b))

As we notified you in our letter of July 7, 2022, 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 June 24, 2022. 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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 06/24/2022

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VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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F 000	INITIAL COMMENTS On 6/21/22 through 6/24/22, 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 immediate jeopardy began on 6/7/22, when R1, who was identified as a high elopement risk, was found on the street off the premises and was identified on 6/22/22. The administrator and assistant director of nursing (ADON) were notified of the immediate jeopardy at 2:10 p.m. on 6/22/22. The immediate jeopardy was removed on 6/24/22, but noncompliance remained at the lower scope and severity level D scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/24/22, which a deficiency cited at F843. The following complaint was found to be SUBSTANTIATED: H53782188C (MN84130), with a deficiency cited at F689. In addition as a result of the investigation, a deficiency was cited at F610. 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2022

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 000	Continued From page 1 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an incident of elopement for 1 of 1 residents (R1) reviewed for elopement, when R1 was found on the street off facility premises. Findings include:	F 610	R 1 risk management incident was completed and thoroughly investigated. R 1 root cause was identified and a plan was implemented. All other incidents from survey exit until present were reviewed for reporting timely to the state agency. Future incidents that require reporting to the state agency will be	7/13/22

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F 610	Continued From page 2 R1's annual Minimal Data Set (MDS) dated 4/20/22, indicated R1 had a diagnosis of dementia and had severe cognitive impairment. R1's Elopement Risk Evaluation dated 5/3/22, indicated R1 was at risk for elopement and required the use of a WanderGuard for safety. Review of facility report to the State Agency (SA) dated 6/7/22, indicated R1 was found by nurse leaving for the day off the nursing home premises. R1 was in his wheelchair. R1 was assessed for injury upon return to the facility and no injuries were noted. R1 had a Wandergard on at the time of incident however it was checked and found to not be working properly (not sounding when entering or exiting facility doors). A new Wandergard was placed on R1. Review of facility's five-day investigation dated 6/13/22, indicated action taken to prevent reoccurrence was for staff to take R1 outside for a walk in the afternoon or around the facility in his wheelchair. Further, investigation indicated to prevent reoccurrence to the other residents who were identified at risk for elopement the staff were directed to check WanderGuard function three times a day each shift as well as add expiration date and model number in the medication administration record (MAR) and WanderGuard's are changed every 60 days (not a change in practice). In addition, a message was sent to family/visitors for each resident to educate them regarding not allowing a resident to follow them out of the building. On 6/22/22, at 8:44 a.m. Stanley sales representative (SSR)-A for the WanderGuard system the facility was using stated the	F 610	reported per facility policy. The facility staff will be in-serviced on the Abuse Investigation Policy with emphasis on item #3 that at a minimum review the completed documentation forms; review the resident□s medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident (as medically appropriate); interview the resident□s Attending Physician as needed to determine the resident□s current level of cognitive function and medical condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident□s roommate, family members, and visitors; interview other residents to whom the accused employee provides care or services; and review all events leading up to the alleged incident. Director of Social Services and/or designee is responsible for compliance. Audits on reporting allegations of abuse being thoroughly investigated/identifying the root cause will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 07/13/2022	

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F 610	Continued From page 3 WanderGuard bracelet will rarely malfunction, however if a bracelet does the facility should keep the bracelet and call Stanley to run diagnostics and evaluate as to why the WanderGuard bracelet could have malfunctioned. Further, SSR-A stated a WanderGuard bracelet should never be placed directly on metal due to metal blocking the signal and the resident would be able to go right through the door. On 6/22/22, at 9:09 a.m. director of nursing (DON) confirmed she completed the investigation following R1's elopement. DON stated she was not at the facility on the day of the incident but stated the staff threw away the defective WanderGuard R1 was wearing at the time of the incident and confirmed the facility did not send it to the manufacturer to be evaluated. Further, DON stated she did not contact Stanley (WanderGuard Manufacturer) or review the Stanley WanderGuard User Manual to determine the cause of the WanderGuard malfunction (not sounding when exiting or entering through the facility doors). In addition, DON stated it would be important to contact the manufacturer as part of the investigation to determine a cause of the malfunction and prevent reoccurrence, however stated she did not think of it. Lastly, the DON was not aware R2's WanderGuard was currently on his wheelchair. Review of Stanley WanderGuard User and Installation Manuel dated 2010, directed for staff to read and follow these instructions carefully before using this system, failure to do so could cause an unauthorized departure resulting in injury or death. Further, WanderGuard manual directed staff the bracelets are designed to be worn only on the resident's dominant wrist and	F 610		

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F 610	Continued From page 4 prior to alternative placement staff are direct to call WanderGuard Customer Services. In addition, WanderGuard Manual directs staff not to place bracelet on or next to metal, such as wheelchair frames as metal could interfere with the signal sent from the bracelet to the door antennas and result in an unauthorized departure. Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, lacked evidence of reviewing facility policies to ensure the policy is in accordance to manufacturer's instructions manual as well as, contacting the manufacturer to report a malfunction of a piece of equipment that should not have malfunctioned to prevent future incidents.	F 610		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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, observation, and document review, the facility failed to provide adequate supervision and safeguards to prevent elopement for by not following manufacturer's guidelines for the use of WanderGuard bracelets for 2 of 2 residents (R1, R2) who were determined to be at risk for elopement and required the use of a WanderGuard for safety resulting in an Immediate Jeopardy. In addition, the facility failed	F 689	R 1 wander management bracelet was replaced and the physician order and care plan was updated with expiration date and site where bracelet is worn. All other residents who wear a wander management bracelet was reviewed and physician order and care plan was updated as needed. For future resident requiring wander guard management, the	7/13/22

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F 689	Continued From page 5 to implement interventions to prevent future elopements and failed to update care plan interventions related to elopement/wandering behaviors for 1 of 2 residents (R1) following an elopement. The immediate jeopardy began on 6/7/22, when R1, who was identified as a high elopement risk, was found on the street off the premises and was identified on 6/22/22. The administrator and assistant director of nursing (ADON) were notified of the immediate jeopardy at 2:10 p.m. on 6/22/22. The immediate jeopardy was removed on 6/24/22, but noncompliance remained at the lower scope and severity level D scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's annual Minimal Data Set (MDS) dated 4/20/22, indicated R1 had a diagnosis of dementia and had severe cognitive impairment. Further, R1 required extensive assist from staff for activities of daily living (ADLs) such as bed mobility, transfers, dressing, toileting, and locomotion off the unit. R1's Elopement Risk Evaluation dated 5/3/22, indicated R1 was at risk for elopement and required the use of a WanderGuard for safety. R1's care plan as of 6/21/22, indicated R1 was at risk for elopement related to impaired safety awareness, statements of wanting to go home and going to the door. Further, R1's care plan directed staff to distract R1 from wandering by offering pleasant diversion, structured activities,	F 689	physician order and care plan will be created per facility policy. The facility nursing and leadership team will be in-serviced on the Wander Management Policy and Procedure with emphasis on item #3 that the wander management system bracelet will be applied to the resident□s dominant wrist (per manufacturer instruction). The wander management bracelet should not be removed until replacement is needed and/or the resident is discharged from the unit or facility. The wander management bracelet expiration date and model # (if available) should be documented in the resident wander management physician order and care plan. This policy was revised during the complaint survey and no further updates are warranted at this time. Director of Nursing and/or designee is responsible for compliance. Audits on wander guard placement, care plan and weekly system checks will begin 2x week for 2 weeks, weekly x 4 weeks then monthly to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 07/13/2022	

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F 689	Continued From page 6 food, conversation, television and book. R1's care plan lacked resident specific interventions for these identified behaviors, implementation of current interventions and lacked evidence of implementing new interventions following R1's elopement on 6/7/22. R2's quarterly MDS dated 4/9/22, indicated R2 had a diagnosis of dementia and R2's cognition was moderately impaired. Further, R2 required supervision by staff for locomotion on or off the unit. R2's Elopement Risk Evaluation dated 4/5/22, indicated R2 was at risk for elopement and required a WanderGuard for safety. Review of facility report to the State Agency (SA) dated 6/7/22, indicated R1 was found by nurse leaving for the day off the nursing home premises (off campus). R1 was in his wheelchair. R1 was assessed for injury upon return to the facility and no injuries were noted. R1 had a Wandergard on at the time of incident however it was checked and found to not be working properly (not sounding when entering or exiting facility doors). A new Wandergard was placed on R1. Review of facility's five-day investigation dated 6/13/22, indicated action taken to prevent reoccurrence was for staff to take R1 outside for a walk in the afternoon or around the facility in his wheelchair. Further, investigation indicated to prevent reoccurrence to the other residents who were identified at risk for elopement the staff were directed to check WanderGuard function three times a day each shift as well as add expiration date and model number in the medication administration record (MAR) and	F 689		

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F 689	Continued From page 7 WanderGuard's are changed every 60 days (not a change in practice). In addition, a message was sent to family/visitors for each resident to educate them regarding not allowing a resident to follow them out of the building. On 6/21/22, at 2:26 p.m. registered nurse (RN)-A stated at approximately 2:45 p.m. on 6/7/22, RN-A finished her shift and was headed home when R1 was observed in his wheelchair on the street at the end of the block. RN-A stated she witnessed R1 standing up attempting to try and get his wheelchair unstuck. RN-A stated she stopped her car in the middle of the road and brought R1 back to the facility. Further, RN-A confirmed she was R1's nurse that morning until the next shift arrived at approximately 2:00 p.m. and RN-A was unsure the last time she observed R1 but stated R1 had went to an activity of live music that afternoon. In addition, RN-A stated R1 was at risk for eloping due to behaviors of exit seeking and confusion and she "almost had a heart attack" when R1 was observed outside. On 6/22/22, at 8:28 a.m. R1 was observed at the nursing station in his wheelchair and WanderGuard was placed on R1's right wrist. On 6/22/22, at 8:59 a.m. R2 was observed in the commons area at the front of the facility in his wheelchair. R2's WanderGuard was observed to be attached directly to the left metal handlebar. On 6/22/22, at 8:44 a.m. Stanley sales representative (SSR)-A for the WanderGuard system the facility was using stated the WanderGuard bracelet will rarely malfunction, however if a bracelet does the facility should keep the bracelet and call Stanley to run diagnostics	F 689		

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F 689	Continued From page 8 and evaluate as to why the WanderGuard bracelet could have malfunctioned. Further, SSR-A stated a WanderGuard bracelet should never be placed directly on metal due to metal blocking the signal and the resident would be able to go right through the door. On 6/22/22, at 9:09 a.m. director of nursing (DON) confirmed she completed the investigation following R1's elopement. DON stated she did not contact the WanderGuard manufacturer (Stanley) or review the Stanley WanderGuard User Manual to determine the cause of the WanderGuard malfunction. Further, DON stated R1's WanderGuard was on R1's wheelchair on the day of the incident, 6/7/22. Following the incident, R1's WanderGuard was removed from the wheelchair and a new bracelet was placed on R1's ankle. On 6/8/22, upon returning to the facility, DON stated she placed another new WanderGuard on R1's wrist. DON added staff are trained to ensure WanderGuard placement is "on the person" rather than on the wheelchair. DON was not aware R2's WanderGuard was currently on his wheelchair. DON confirmed the facility did not assess other residents at risk and no re-education was completed following the elopement on 6/7/22. DON confirmed the facility increased testing WanderGuard units on every shift daily (were testing once daily before incident) and stated a letter was sent to families and guardians with friendly reminder to ensure they were not letting residents exit the building when leaving as this was the conclusion to how R1 may have left the building (despite the WanderGuard unit still not alarming). On 6/22/22, at 11:46 a.m. administrator stated during the investigation it was determined R1's	F 689		

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F 689	Continued From page 9 WanderGuard was ordered to be changed on 5/25/22, however when the nurse was interviewed, she misunderstood the order and R1's WanderGuard was not changed since 3/26/22, which was still within the 90-day expiration date range for the WanderGuard. Administrator confirmed after reviewing R1 and R2's MAR a new order was not implemented as indicated as an intervention in the facility's 5-day investigation to prevent reoccurrence to include the expiration date and model number for the WanderGuard in their record. Further, administrator stated management determined two root causes for R1's incident which included R1's battery on his WanderGuard died and the other a volunteer holding the door open for R1. Administrator stated there was a message sent to each resident's family to educate on resident safety and not holding the door open for a resident to follow them out of the facility, however administrator indicated unexpected visitors did not receive this information. Administrator confirmed there was no education provided to staff following the incident of R1 eloping related to WanderGuard placement, responding to the alarms, educating visitors when they are leaving, or on the updated Wander Management policy because staff are educated as part of their new hire orientation and there had not been an issue in the past. Administrator confirmed the manufacturer for the WanderGuard was not called and updated on the bracelet malfunction because "it was just the one bracelet that failed, and they do fail once in a while". In addition, administrator indicated the facility's policy for placement of WanderGuard bracelet was either the wrist or ankle however at times the WanderGuard had been placed on a wheelchair, which administrator confirmed she was not aware	F 689		

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F 689	Continued From page 10 a WanderGuard could not be placed on a wheelchair On 6/22/22, at 11:08 a.m. licensed practical nurse (LPN)-A stated staff was directed to place a WanderGuard based on each resident's mobility for example, if the resident were ambulatory the bracelet would need to be on the resident but if the resident were wheelchair bound then the bracelet would be placed on the resident's wheelchair. On 6/22/22, at 11:21 a.m. RN-A confirmed R1's WanderGuard was on his wheelchair the day of the incident. RN-A stated staff were directed to place the WanderGuard's on the resident's wrist or ankles however if the resident had a history of removing the bracelet staff were directed to place the bracelet on the resident's wheelchair. In addition, RN-A stated R1 had a history of removing his bracelet when placed on his wrist or ankle. On 6/22/22, at 1:17 p.m. MDS coordinator stated R1 displayed behaviors of wandering and exit seeking in the afternoon and was not sure which interventions were in place at this time other than distractions and taking R1 for a walk for staff to use when R1 is displaying these behaviors. MDS coordinator was not aware R1's care plan was not updated following R1's elopement on 6/7/22, to include taking R1 for a walk outside or in the facility if he begins to show wandering or exit seeking behaviors. Further, MDS coordinator stated resident care plans were expected to be updated at least quarterly and as needed when there are changes to ensure all staff are aware of what to do to help each resident and take care of each resident.	F 689		

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F 689	Continued From page 11 Review of Stanley WanderGuard User and Installation Manuel dated 2010, directed for staff to read and follow these instructions carefully before using this system, failure to do so could cause an unauthorized departure resulting in injury or death. Further, WanderGuard manual directed staff the bracelets are designed to be worn only on the resident's dominant wrist and prior to alternative placement staff are direct to call WanderGuard Customer Services. In addition, WanderGuard Manual directs staff not to place bracelet on or next to metal, such as wheelchair frames as metal could interfere with the signal sent from the bracelet to the door antennas and result in an unauthorized departure. Review of facility policy titled Wander Management System updated on 6/7/22, directed staff the wander management system bracelet will be applied to the resident's wrist or ankle. The wander management bracelet expiration date and model number should be documented in the resident wander management physician order. In addition, facility policy directs staff to check bracelet function and placement every shift. The immediate jeopardy that began on 6/7/22, was removed at 12:54 p.m. on 6/24/22, when the facility reassessed all residents who were at a high risk for elopement, reviewed each resident's care plan and updated to include current elopement risk interventions, Stanley WanderGuard manufacturer was contacted related to the malfunction, Wander Management Policy was reviewed and updated to comply with manufacturer's instructions for placement of WanderGuard, all staff were educated on the updated Wander Management Policy in person,	F 689		

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 06/24/2022

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 689	Continued From page 12 phone, and prior to beginning of their next shift and WanderGuard placement was moved to only residents person.	F 689		
F 843 SS=F	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced	F 843		7/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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F 843	Continued From page 13 by: Based on interview and document review, the facility failed to have a written transfer agreement with a hospital approved for participation under Medicare or Medicaid programs, which reasonably ensured that residents would be transferred to the hospital and ensured timely admission. This has the potential to affect all residents requiring hospital transportation. Findings include: During a review of the facility's policies and procedures, the facility's transfer agreement with a hospital was requested. During an interview on 6/24/22, at 12:54 p.m. the facility Administrator verified the facility staff were unable to locate a transfer agreement from any hospital and stated, "I cannot find the transfer agreement with the hospital and have a call out to the hospital however who I need to speak with is out for the day". Further, administrator stated staff were expected to call the primary for the resident and get orders to transfer, call emergency services to transfer New Ulm which would be the closest hospital. On 6/24/22, at 4:39 p.m. Administrator sent a transfer agreement to surveyor via email. The transfer agreement was between Valley View Manor Nursing Home and Allina Health System Hospitals and Clinics, however dated as of 6/24/22. Facility policy for transfer agreement with hospital requested, but facility failed to provide a policy.	F 843	The facility hospital agreement was located with an original date of 2015. A new hospital agreement was signed and dated for 6/24/2022. The emergency preparedness plan will be reviewed and updated for current contact information. The Administrator was in-serviced by the Corporate VP on the Emergency Management Plan policy with emphasis on item # The Emergency Management Plan the at plan is reviewed and updated at minimum annually to ensure its accuracy. The Administrator and/or designee is responsible for compliance. Audits on the emergency preparedness contact information will be audited weekly x 2 weeks then monthly x 3 to ensure compliance. Audit results will be reviewed by the Administrator and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 07/13/2022	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 26, 2022

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

Re: Reinspection Results
Event ID: CHWZ12

Dear Administrator:

On July 20, 2022 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 June 24, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted
July 7, 2022

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

RE: CCN: 245378
Cycle Start Date: June 24, 2022

Dear Administrator:

On June 24, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety 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.

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. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 24, 2022, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 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 July 22, 2022.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 22, 2022, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 22, 2022, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 24, 2022. This prohibition is not subject to appeal. 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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require 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.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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" and/ or "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 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 December 24, 2022 (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 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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 Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 7, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: CHWZ11

Dear Administrator:

The above facility was surveyed on June 21, 2022 through June 24, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
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
	00731	A. BUILDING: _____ B. WING _____	C 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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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 6/21/22 through 6/24/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H53782188C (MN84130) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review, the facility failed to provide adequate supervision and safeguards to prevent elopement for by not following manufacturer's guidelines for the use of WanderGuard bracelets for 2 of 2 residents (R1, R2) who were determined to be at risk for elopement and required the use of a WanderGuard for safety resulting in an Immediate Jeopardy. In addition, the facility failed to implement interventions to prevent future	2 830	Corrected	7/13/22

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 06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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2 830	Continued From page 3 elopements and failed to update care plan interventions related to elopement/wandering behaviors for 1 of 2 residents (R1) following an elopement. The immediate jeopardy began on 6/7/22, when R1, who was identified as a high elopement risk, was found on the street off the premises and was identified on 6/22/22. The administrator and assistant director of nursing (ADON) were notified of the immediate jeopardy at 2:10 p.m. on 6/22/22. The immediate jeopardy was removed on 6/24/22, but noncompliance remained at the lower scope and severity level D scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's annual Minimal Data Set (MDS) dated 4/20/22, indicated R1 had a diagnosis of dementia and had severe cognitive impairment. Further, R1 required extensive assist from staff for activities of daily living (ADLs) such as bed mobility, transfers, dressing, toileting, and locomotion off the unit. R1's Elopement Risk Evaluation dated 5/3/22, indicated R1 was at risk for elopement and required the use of a WanderGuard for safety. R1's care plan as of 6/21/22, indicated R1 was at risk for elopement related to impaired safety awareness, statements of wanting to go home and going to the door. Further, R1's care plan directed staff to distract R1 from wandering by offering pleasant diversion, structured activities, food, conversation, television and book. R1's care plan lacked resident specific interventions for	2 830		

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2 830	Continued From page 4 these identified behaviors, implementation of current interventions and lacked evidence of implementing new interventions following R1's elopement on 6/7/22. R2's quarterly MDS dated 4/9/22, indicated R2 had a diagnosis of dementia and R2's cognition was moderately impaired. Further, R2 required supervision by staff for locomotion on or off the unit. R2's Elopement Risk Evaluation dated 4/5/22, indicated R2 was at risk for elopement and required a WanderGuard for safety. Review of facility report to the State Agency (SA) dated 6/7/22, indicated R1 was found by nurse leaving for the day off the nursing home premises (off campus). R1 was in his wheelchair. R1 was assessed for injury upon return to the facility and no injuries were noted. R1 had a Wandergard on at the time of incident however it was checked and found to not be working properly (not sounding when entering or exiting facility doors). A new Wandergard was placed on R1. Review of facility's five-day investigation dated 6/13/22, indicated action taken to prevent reoccurrence was for staff to take R1 outside for a walk in the afternoon or around the facility in his wheelchair. Further, investigation indicated to prevent reoccurrence to the other residents who were identified at risk for elopement the staff were directed to check WanderGuard function three times a day each shift as well as add expiration date and model number in the medication administration record (MAR) and WanderGuard's are changed every 60 days (not a change in practice). In addition, a message was sent to family/visitors for each resident to educate	2 830		

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2 830	Continued From page 5 them regarding not allowing a resident to follow them out of the building. On 6/21/22, at 2:26 p.m. registered nurse (RN)-A stated at approximately 2:45 p.m. on 6/7/22, RN-A finished her shift and was headed home when R1 was observed in his wheelchair on the street at the end of the block. RN-A stated she witnessed R1 standing up attempting to try and get his wheelchair unstuck. RN-A stated she stopped her car in the middle of the road and brought R1 back to the facility. Further, RN-A confirmed she was R1's nurse that morning until the next shift arrived at approximately 2:00 p.m. and RN-A was unsure the last time she observed R1 but stated R1 had went to an activity of live music that afternoon. In addition, RN-A stated R1 was at risk for eloping due to behaviors of exit seeking and confusion and she "almost had a heart attack" when R1 was observed outside. On 6/22/22, at 8:28 a.m. R1 was observed at the nursing station in his wheelchair and WanderGuard was placed on R1's right wrist. On 6/22/22, at 8:59 a.m. R2 was observed in the commons area at the front of the facility in his wheelchair. R2's WanderGuard was observed to be attached directly to the left metal handlebar. On 6/22/22, at 8:44 a.m. Stanley sales representative (SSR)-A for the WanderGuard system the facility was using stated the WanderGuard bracelet will rarely malfunction, however if a bracelet does the facility should keep the bracelet and call Stanley to run diagnostics and evaluate as to why the WanderGuard bracelet could have malfunctioned. Further, SSR-A stated a WanderGuard bracelet should never be placed directly on metal due to metal	2 830		

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2 830	Continued From page 6 blocking the signal and the resident would be able to go right through the door. On 6/22/22, at 9:09 a.m. director of nursing (DON) confirmed she completed the investigation following R1's elopement. DON stated she did not contact the WanderGuard manufacturer (Stanley) to determine the cause of the WanderGuard malfunction. Further, DON stated R1's WanderGuard was on R1's wheelchair on the day of the incident, 6/7/22. Following the incident, R1's WanderGuard was removed from the wheelchair and a new bracelet was placed on R1's ankle. On 6/8/22, upon returning to the facility, DON stated she placed another new WanderGuard on R1's wrist. DON added staff are trained to ensure WanderGuard placement is "on the person" rather than on the wheelchair. DON was not aware R2's WanderGuard was currently on his wheelchair. DON confirmed the facility did not assess other residents at risk and no re-education was completed following the elopement on 6/7/22. DON confirmed the facility increased testing WanderGuard units on every shift daily (were testing once daily before incident) and stated a letter was sent to families and guardians with friendly reminder to ensure they were not letting residents exit the building when leaving as this was the conclusion to how R1 may have left the building (despite the WanderGuard unit still not alarming). On 6/22/22, at 11:46 a.m. administrator stated during the investigation it was determined R1's WanderGuard was ordered to be changed on 5/25/22, however when the nurse was interviewed, she misunderstood the order and R1's WanderGuard was not changed since 3/26/22, which was still within the 90-day expiration date range for the WanderGuard.	2 830		

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2 830	Continued From page 7 Administrator confirmed after reviewing R1 and R2's MAR a new order was not implemented as indicated as an intervention in the facility's 5-day investigation to prevent reoccurrence to include the expiration date and model number for the WanderGuard in their record. Further, administrator stated management determined two root causes for R1's incident which included R1's battery on his WanderGuard died and the other a volunteer holding the door open for R1. Administrator stated there was a message sent to each resident's family to educate on resident safety and not holding the door open for a resident to follow them out of the facility, however administrator indicated unexpected visitors did not receive this information. Administrator confirmed there was no education provided to staff following the incident of R1 eloping related to WanderGuard placement, responding to the alarms, educating visitors when they are leaving, or on the updated Wander Management policy because staff are educated as part of their new hire orientation and there had not been an issue in the past. Administrator confirmed the manufacturer for the WanderGuard was not called and updated on the bracelet malfunction because "it was just the one bracelet that failed, and they do fail once in a while". In addition, administrator indicated the facility's policy for placement of WanderGuard bracelet was either the wrist or ankle however at times the WanderGuard had been placed on a wheelchair, which administrator confirmed she was not aware a WanderGuard could not be placed on a wheelchair On 6/22/22, at 11:08 a.m. licensed practical nurse (LPN)-A stated staff was directed to place a WanderGuard based on each resident's mobility for example, if the resident were ambulatory the	2 830		

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2 830	Continued From page 8 bracelet would need to be on the resident but if the resident were wheelchair bound then the bracelet would be placed on the resident's wheelchair. On 6/22/22, at 11:21 a.m. RN-A confirmed R1's WanderGuard was on his wheelchair the day of the incident. RN-A stated staff were directed to place the WanderGuard's on the resident's wrist or ankles however if the resident had a history of removing the bracelet staff were directed to place the bracelet on the resident's wheelchair. In addition, RN-A stated R1 had a history of removing his bracelet when placed on his wrist or ankle. On 6/22/22, at 1:17 p.m. MDS coordinator stated R1 displayed behaviors of wandering and exit seeking in the afternoon and was not sure which interventions were in place at this time other than distractions and taking R1 for a walk for staff to use when R1 is displaying these behaviors. MDS coordinator was not aware R1's care plan was not updated following R1's elopement on 6/7/22, to include taking R1 for a walk outside or in the facility if he begins to show wandering or exit seeking behaviors. Further, MDS coordinator stated resident care plans were expected to be updated at least quarterly and as needed when there are changes to ensure all staff are aware of what to do to help each resident and take care of each resident. Review of Stanley WanderGuard User and Installation Manuel dated 2010, directed for staff to read and follow these instructions carefully before using this system, failure to do so could cause an unauthorized departure resulting in injury or death. Further, WanderGuard manual directed staff the bracelets are designed to be	2 830		

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2 830	Continued From page 9 worn only on the resident's dominant wrist and prior to alternative placement staff are direct to call WanderGuard Customer Services. In addition, WanderGuard Manual directs staff not to place bracelet on or next to metal, such as wheelchair frames as metal could interfere with the signal sent from the bracelet to the door antennas and result in an unauthorized departure. Review of facility policy titled Wander Management System updated on 6/7/22, directed staff the wander management system bracelet will be applied to the resident's wrist or ankle. The wander management bracelet expiration date and model number should be documented in the resident wander management physician order. In addition, facility policy directs staff to check bracelet function and placement every shift. The immediate jeopardy that began on 6/7/22, was removed at 12:54 p.m. on 6/24/22, when the facility reassessed all residents who were at a high risk for elopement, reviewed each resident's care plan and updated to include current elopement risk interventions, Stanley WanderGuard manufacturer was contacted related to the malfunction, Wander Management Policy was reviewed and updated to comply with manufacturer's instructions for placement of WanderGuard, all staff were educated on the updated Wander Management Policy in person, phone, and prior to beginning of their next shift and WanderGuard placement was moved to only residents person. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to appropriate supervision to prevent elopement or respond to exit-seeking behavior. The DON or	2 830		

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2 830	Continued From page 10 designee could also and ensure appropriate comprehensive assessments and interventions were developed and implemented for all residents with the potential to be affected. The DON or designee could re-educate all staff on policies and procedures, changes to care plans, and the results of assessments for those identified at risk for exit-seeking behaviors and elopement. The DON or designee could develop a system for evaluating and monitoring consistent implementation of policies and procedures and audit to prevent potential elopements and/identify exit-seeking behaviors. The DON or designee should also ensure staff perform a comprehensive assessment or root cause analysis as needed to ensure interventions are effective, in place and re-evaluated as often as necessary. The results of those measurable audits should be routinely brought to the facility's Quality Assurance Performance Improvement (QAPI) committee to determine ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		