Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

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

RE: CCN: 245378
Cycle Start Date: August 21, 2023

Dear Administrator:

On October 19, 2023, we notified you a remedy was imposed. On November 8, 2023 the Minnesota Departments of Health and Public Safety 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 November 6, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 4, 2023 be discontinued as of November 6, 2023. (42 CFR 488.417 (b))

In our letter of October 19, 2023, 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 October 4, 2023. 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
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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August 31, 2023

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

RE: CCN: 245378
Cycle Start Date: August 21, 2023

Dear Administrator:

On August 21, 2023, 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 November 21, 2023, (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 February 21, 2024, (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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 19, 2023

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

Re: Event ID: U56F11

Dear Administrator:

The above facility survey was completed on August 21, 2023, 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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@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 08/21/2023

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 8/17/23 and 8/21/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53784612C (MN00095972) with a deficiency issued at F609 and 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 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		9/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/01/2023

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 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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 report an allegation of resident-to-resident abuse immediately or no later than two (2) hours to the State Agency for 2 of 3 residents (R1 and R2). In addition, the facility failed to report an allegation of resident-to-resident sexual abuse to the State Agency (SA) for 2 of 3 residents (R1 and R3) reviewed for abuse. Findings include: R1 and R2 A Facility Reported Incident (FRI) submitted to the State Agency on 8/11/23, at 1:55 a.m., alleged R1 punched R2 in the face. The resident-to-resident altercation occurred on 8/10/23, at 9:35 p.m. During an interview on 8/17/23 at 11:35 a.m., the	F 609	F 609 A risk management incident was created and thoroughly reviewed for root cause for both R 1, R 2 and R 3. A new vulnerable adult assessment was completed for all. The root cause was identified, and R 1 and R 2 care plan interventions were updated as needed. R 3 was placed on a 1:1, was evaluated by the MD on 8/29 and the provider requested he be removed from 1:1 observation. There have been no further incidents reported for R 3. Future allegations of abuse will be reported timely per facility Abuse Reporting Policy. All facility staff were in-serviced on the Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy with emphasis on reporting all suspicions of abuse immediately but no later than 2 hours for	

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F 609	Continued From page 2 director of nursing (DON) stated certified nursing assistant (CNA)-A notified her of the altercation between R1 and R2 on 8/11/23, at 12:30 a.m. The DON indicated the on-duty charge nurse at the time of the altercation did not notify her of the incident which caused the vulnerable adult (VA) report to be submitted late. R1 and R3 During an interview on 8/17/23 at 12:25 p.m., registered nurse (RN-A) stated R1 was aggressive and impulsive at times and had heard from other staff that R1 had placed his hand on R3's leg. She indicated R3 would not be able to stop him or move away from R1 due to her physical and cognitive impairments. RN-A stated she did not know if the incident had been reported to the SA. She explained all allegations of abuse were required to go through the chain of command before a report was made to the SA. RN-A indicated the chain of command consisted of the social worker (SW), DON, the administrator, and the corporate regional nurse made the final decision on whether to report to the SA or not. During an interview on 8/17/23 at 1:20 p.m., licensed practical nurse (LPN)-A stated R1 was sexually inappropriate, verbally aggressive, and physically aggressive with staff and other residents at times. LPN-A indicated on 8/5/23, after lunch, CNA-A, CNA-B, and CNA-C informed her R1 was rubbing R3's leg and arm in the dining room. LPN-A stated she contacted the DON and was told since there was no harm, attempt to keep them apart, and not to document the incident. As a result, LPN-A did not report the incident to the SA, document the incident, or	F 609	allegations of abuse. Social Services and/or designee is responsible for compliance. Audits on timely reporting to the state agency for allegations of abuse will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will deliver results to QAPI for review and recommendation. Compliance: 9/5/2023	

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F 609	Continued From page 3 notify R3's responsible party of the allegation. LPN-A confirmed R3 did not have the capacity to consent to the touch, verbally tell R1 to stop, or move away from him. LPN-A stated she felt it was a reportable incident (to the SA). During an interview on 8/17/23 at 1:35 p.m., CNA-D stated R1's behaviors were very unpredictable and made the female staff "uncomfortable" when he frequently used sexually explicit vulgar language, tried to kiss, and grab them in inappropriate places. She indicated there had been an incident in the dining room when R1 was rubbing on R3's thigh and was "very angry" the incident had not been reported (to the SA). CNA-D stated she felt it should have been reported and was not sure why it had not been reported. During an interview on 8/17/23 at 1:50 p.m., CNA-A stated on 8/5/23, during lunch time in the dining room, he witnessed R1 lean back in his wheelchair as far as he could go back, rubbed R3's upper leg and tried to reach further up towards her "private area" however since R1's wheelchair brakes were locked, he could not lean back any further. CNA-A stated he requested assistance from another CNA, and they separated the two of them. CNA-A informed LPN-A about the incident and was not sure what happened with the information. CNA-A indicated R3 could not move away or stop R1 from touching her. CNA-A stated he felt the touch was inappropriate and if R3 had been his family member, he would have been upset. During an interview on 8/17/23 at 2:10 p.m., CNA-B indicated on 8/5/23, she was serving lunch trays in the dining room when CNA-A	F 609		

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F 609	Continued From page 4	F 609		

informed her R1 was rubbing R3's leg. CNA-B then noted R1 to have his hand on R3's outer mid-thigh so they immediately separated them and told LPN-A. CNA-B stated the incident "absolutely should have been reported" (to the SA).

During an interview on 8/17/23 at 2:25 p.m., SW indicated she was aware of the incident when R1 placed his hand on R3's upper leg and moved his hand up the leg toward her "privates". SW stated the incident had been reviewed by the DON, administrator, and nurse consultant and she was informed the incident did not need to be reported to the SA. The SW indicated the DON, administrator, and nurse consultant must give their permission before a report could be submitted to the SA.

During an interview on 8/17/23 at 4:15 p.m., the DON stated on Saturday 8/5/23, she was notified by LPN-A that R1 had placed his hand on R3's arm and leg. The DON checked their policy and did not think it needed to be reported. The DON returned to the facility on Monday 8/7/23, and she heard some staff thought it needed to be reported however felt the story got "blown out of proportion". DON verified the incident had not been reported to the SA.

During an interview on 8/17/23 at 4:25 p.m., the administrator stated she received a notification via text that R1 had touched R3's arm and leg however staff intervened immediately. She explained she heard the word "patted" and was not aware of all the information.

During an interview on 8/21/23 at 1:50 p.m., the corporate regional nurse stated staff were

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F 609	Continued From page 5 expected to report any allegation of abuse to the DON and administrator and they would submit the VA reports to the SA. She indicated she had been notified R1 touched a lady's arm and knee however did not know the residents so did not realize it was unwanted touch. She verified, with the new information presented to her, it was a reportable VA incident. The Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy last reviewed 3/22/23, indicated when resident abuse, exploitation, misappropriation of resident property or injury of unknown source was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reported his or her suspicion to the state licensing/certification agency responsible for surveying/licensing the facility, the ombudsman (per Ombudsman direction/preference), adult protective services, law enforcement officials, the resident's attending physician and the facility medical director. Immediately was defined as within two hours of an allegation involving abuse or results in serious bodily injury.	F 609		
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,	F 610		9/5/23

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F 610	Continued From page 6 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 ensure a thorough investigation of an allegation of potential sexual abuse was completed for 1 of 3 residents (R1) reviewed for abuse. In addition, the facility failed to protect residents after an allegation of abuse occurred for 1 of 3 residents (R3) reviewed for abuse. Findings include: R1 R1's admission Minimum Data Set (MDS) dated 7/3/23, identified R1 had severe cognitive impairment. R1 was exhibiting signs of impulsiveness, lack of safety awareness, and socially inappropriate statements. R1's diagnoses included dementia with agitation. R1's care plan initiated 6/29/23, indicated R1 was at risk for elopement related to disorientation and impaired safety awareness. Care plan was updated on 8/11/23, to reflect R1 had the potential to be physically aggressive related to history of harm to others, poor impulse control, and lack of safety awareness. R1 could become physically aggressive when interacting with	F 610	F 610 A risk management incident was created and thoroughly reviewed for root cause for both R 1, R 2 and R 3. A new vulnerable adult assessment was completed for all. The root cause was identified, and R 1 and R 2 care plan interventions were updated as needed. R 3 was placed on a 1:1, was evaluated by the MD on 8/29 and the provider requested he be removed from 1:1 observation. There have been no further incidents reported for R 3. Future allegations of abuse will be reported thoroughly investigated per facility Abuse Reporting Policy. IDT team was in-serviced on the Abuse, Neglect, Exploitation or Misappropriation Reporting and Investigating policy with emphasis on the investigation allegation section items #1 for thoroughly reviewing the allegation and item #7 that interviews must take place with all parties involved and reviews all incidents leading up to the event. Social Services and/or designee is responsible for compliance. Audits on thoroughly investigation	

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F 610	Continued From page 7 others. The care plan lacked identification of potential of sexual aggressive, verbal and physical behaviors. R1's progress notes (PN) were reviewed on 8/17/23. The PN lacked documentation of the allegation of resident-to-resident sexual abuse which occurred on 8/5/23. The PN did note socially inappropriate actions and comments to staff on the following dates: 7/18/23, 7/20/23, 7/25/23, 8/3/23, 8/6/23, 8/9/23, and on 8/10/23 which included physical abuse to a different resident. R3 R3's change of condition Minimum Data Set (MDS) dated 7/24/23, identified R3 had severe cognitive impairment and was totally dependent on staff for all cares. R3's medical diagnoses included dementia, left sided hemiplegia (paralysis) due to a recent cerebral infarction (type of stroke caused by impaired blood flow to the brain). R3's care plan dated 6/29/23, identified R3 was at risk for potential abuse related cognitive impairment, dementia, poor decision making, lack of safety awareness, and communication deficits. R3 did not walk and was dependent on staff for meeting emotional, intellectual, physical, and social needs. R3's medical record (MR) PN lacked documentation of the alleged resident-to-resident sexual abuse on 8/5/23. In addition, R3's MR lacked a post incident assessment of potential injury or trauma.	F 610	allegations with written statements documented and reviewed will begin 2x week for 2 weeks, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator and the Administrator will deliver results to QAPI for review and recommendation. Compliance: 9/5/2023	

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(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 610	Continued From page 8	F 610		

During an interview on 8/17/23, at 12:25 p.m., registered nurse (RN-A) stated R1 was aggressive and impulsive at times and was aware that R1 had placed his hand on R3's leg. She indicated R3 would not be able to stop him or move away from R1 due to her physical and cognitive impairments. RN-A stated she was not aware if the incident had been investigated nor if any interventions for protection for R3 had been put in place.

During an interview on 8/17/23 at 1:20 p.m., licensed practical nurse (LPN)-A stated R1 was sexually inappropriate, verbally aggressive, and physically aggressive with staff and other residents at times. LPN-A indicated on 8/5/23, after lunch, certified nursing assistant (CNA)-A, CNA-B, and CNA-C informed her R1 was rubbing R3's leg and arm in the dining room. LPN-A stated she contacted the DON and was directed since there was no harm to just attempt to keep them apart and not to document the incident. As a result, LPN-A indicated she did not investigate, do a risk management report, document the incident in the MR, notify R3's responsible party of the allegation, or change anything in R1 or R3's plan of care to provide protection for R3 to prevent the incident from occurring again. LPN-A confirmed R3 lacked the capacity to consent to the touch, verbally tell R1 to stop, or move away from him.

During an interview on 8/17/23 at 1:35 p.m., CNA-D stated R1's behaviors were very unpredictable and made the female staff "uncomfortable" when he frequently used sexually explicit vulgar language, attempted to kiss and grab them in inappropriate places. She indicated there had been an incident in the dining room

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 08/21/2023

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when R1 was rubbing on R3's thigh. CNA-D was unaware of any protective measures put in place except to try to keep R1 away from R3 however stated their staff could not keep an eye on R1 all the time and he was able to move around the facility on his own.

During an interview on 8/17/23 at 1:50 p.m., CNA-A stated on 8/5/23, during the noon lunch in the dining room, he observed R1 lean back in his wheelchair as far as he could, rub R3's upper leg, attempt to reach further up towards her "private area" however R1's wheelchair brakes were locked and he could not lean back any further. CNA-A stated he requested assistance from another CNA and they separated the two residents. CNA-A informed LPN-A about the incident however did not know what happened with the information from there. CNA-A indicated R3 could not move away or stop R1 from touching her independently. CNA-A stated he felt the touch was inappropriate and if R3 was his family member, he would have been upset about the incident.

During an interview on 8/17/23 at 2:10 p.m., CNA-B indicated on 8/5/23, she was serving lunch trays in the dining room when CNA-A informed her R1 was rubbing R3's leg. CNA-B then observed R1 to have his hand on R3's outer mid-thigh so they immediately separated them and informed LPN-A about the incident.

During an interview on 8/17/23 at 2:25 p.m., SW indicated she was aware of the incident when R1 placed his hand on R3's upper leg and moved his hand up the leg toward her "privates". SW stated the incident had been reviewed by the DON, administrator, and nurse consultant.

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During an interview on 8/17/23 at 4:15 p.m., the DON stated on Saturday 8/5/23, she was notified by LPN-A that R1 had placed his hand on R3's arm and leg. The DON returned to the facility on Monday 8/7/23, and she heard more information related to the incident and thought the story got "blown out of proportion". DON verified the incident had not been investigated nor had protective measures been put in place for R3.

During a follow up interview on 8/21/23 at 11:30 p.m., the DON stated an investigation had been initiated after learning new information.

During an interview on 8/17/23 at 4:25 p.m., the administrator stated she received a notification via text that R1 had touched R3's arm and leg and staff intervened immediately. She further explained she heard the word "patted" and was not aware of all the new information.

The facility lacked documentation, risk management, or investigative notes of the 8/5/23 incident until 8/17/23. In addition, the facility lacked any protection measures put in place for R3 and other residents until the resident-to-resident physical abuse on 8/10/23, which identified R1 as the aggressor.

The Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy last reviewed 3/22/23, indicated if resident abuse, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. All allegations are thoroughly investigated. The individual

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F 610	Continued From page 11 conducting the investigation as a minimum: reviews the documents and evidence; reviews the resident medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; observes the alleged victim, interviews the person reporting the incident; interviews any witnesses to the incident; interviews the resident or representative; interviews staff members on all shift who have had contact with the resident during the period of the alleged incident; reviews all events leading up to the alleged incident, and documents the investigation completely and thoroughly. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of the residents.	F 610		

Minnesota Department of Health

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2 000	Initial Comments	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 8/17/23 and 8/21/23, 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 complaints were reviewed:

Minnesota Department of Health

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2 000	Continued From page 1 H53784612C (MN00095972). No licensing orders were issued. 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		