DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 15, 2023

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

RE: CCN: 245378
Cycle Start Date: November 15, 2023

Dear Administrator:

On December 14, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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Electronically delivered

December 15, 2023

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

Re: Reinspection Results
Event ID: L2XI12

Dear Administrator:

On December 14, 2023 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 November 15, 2023. 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
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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December 4, 2023

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

RE: CCN: 245378
Cycle Start Date: November 15, 2023

Dear Administrator:

On November 15, 2023, a survey was completed at your facility by the Minnesota Departments 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 February 15, 2024, (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 May 15, 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
December 4, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: L2XI11

Dear Administrator:

The above facility was surveyed on November 14, 2023, through November 15, 2023, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 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 11/15/2023

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 11/14/23 and 11/15/23, 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 complaint was reviewed: H53787087C (MN00098348) with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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:	F 689		12/11/23

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

Electronically Signed | 12/08/2023

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 689	Continued From page 1 Based on observation, interview, and document review the facility failed to complete comprehensively assess and provide adequate of level of supervision to prevent elopement for 1 of 1 residents (R1) who had a history of elopements and fall with fracture. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency (SA) on 11/7/23 at 12:36 p.m., indicated R1 eloped from the facility on 11/5/23 and continues to leave facility unsupervised and without staff knowledge. Indicated R1 is at a high risk for falls and further injury due to a recent fall on 10/30/23, which resulted in R1 obtaining a fracture of the right lower leg, The report further indicated R1 was not to bear weight on the right leg and always wear a knee immobilizer but R1 refused to follow the orders. R1's face sheet indicated R1 had a guardian. R1's annual Minimum Data Set (MDS) dated 10/25/23, identified R7 had intact cognition and was independent with transferring and ambulating. R1 used a walker. R1 did not exhibit rejection of cares. R1's diagnoses included alcohol use disorder, post-traumatic stress disorder (PTSD), anxiety, depression, osteoporosis, seizure disorder, and a history of falls. R1's Elopement Risk Evaluation dated 10/25/23, identified R1 was at risk for elopement. Interventions implemented were a check in and check out log, staff is aware of elopement risk and personalization of room.	F 689	F 689 A risk management incident will be created for each elopement incident and will be thoroughly investigated for root cause. R1 care plan, smoking assessment and elopement risk assessment was updated to include 15-min checks, to remind R1 to not leave the facility without supervision, visually monitor resident during smoking times, along with the physician order LOA order being updated. Current residents who are an elopement risk their care plan and elopement assessments were reviewed and updated as needed. Future residents will continue to be assessed for elopement status and if elopement occurs, the resident will be reassessed, care plan and orders will be updated per facility policy. Facility IDT team was in-serviced on the Elopement Policy and Procedure with emphasis on items #4 and 5 of notifying the MD, family, IDT team and reporting this elopement to the state agency. Reports for each elopement must be initiated and thoroughly investigated. DON and/or designee is responsible for compliance. Audits on reporting incidents into the state agency timely and following the supervision/safety of resident care plan interventions will begin 2x week for 1-week, weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation.	

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F 689	Continued From page 2 R1's Smoking Observation dated 11/1/23, indicated R1 smoked 15-20 cigarettes a day, is able to move without assistance to the designated smoking area, is able to make safe decisions, smoking materials kept at the nursing station with the conclusion that R1 can smoke without supervision. R1's elopement care plan last revised on 11/8/23, included R1 is an elopement risk related to history of making poor decision, impulsivity, and leaving the facility. Corresponding interventions directed the following: -Assess elopement status quarterly and as needed (start date 7/15/21) -Discuss with (R1's) court appointed guardian guidelines R1 was to follow for leaving (start date 7/28/23) -Identify pattern of wandering and intervene as appropriate (start date 11/1/23). R1's smoking care plan last revised on 7/15/23, identified R1 as a smoker and included the interventions from the evaluation completed on 11/1/23, however the care plan did not identify R1's required level of supervision while he was outside smoking. Progress note dated 10/31/23 at 4:09 p.m., R1 returned from the emergency room (ER) with orders to wear knee immobilizer at all times and not to put any weight on the right leg (due to leg fracture from a fall in facility). R1's transfer care plan was not revised until 11/8/23, which directed staff to encourage R1 to utilize one staff assist as he has an order to remain non-weight bearing to lower extremity.	F 689	Compliance: 12/11/2023	

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F 689	Continued From page 3 Progress note dated 11/1/23 at 11:14 a.m., R1's smoking observation completed and resident able to smoke independently (outside). Progress note dated 11/4/23 at 10:39 a.m., included R1 states he is going to leave the building to go to the gas station to get more energy drinks. The note indicated staff encouraged R1 to stay in the facility. Progress note dated 11/5/23 at 4:25 p.m., indicated R1 had informed staff he was going to the gas station and left facility independently after staff asked him not to. R1 was located downtown by staff. R1 had walked across a major highway to the gas station (approximately one mile) and was walking back to the facility. R1 stated he just had to get away from the nursing home. Staff re-educated him to the dangers of walking on a fractured leg upon return. Progress note dated 11/5/23 at 9:30 p.m., included R1's alignment of [leg] fracture appears to be less symmetrical than the prior evening and swollen. The note indicated R1 was complaining of more pain. Progress note dated 11/7/23 at 11:44 p.m., indicated the facility received orders R1 was "NOT OK" for leave of absence due to demonstrated need for guardianship, repeated falls, relapse of chronic alcohol usage, and acute nondisplaced fracture of leg. R1's impaired thought process care plan revised on 11/8/23, directed "If resident attempts to leave facility, educate resident on safety concerns, offer alternatives to leaving-having someone get items as needed/wanted. If continues to leave-contact	F 689		

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F 689	Continued From page 4 911 then update Guardian. When resident returns: assess for injuries/intoxification. Follow care plan if intoxicated." Progress note dated 11/11/23 at 2:13 p.m., indicated R1 had left the facility without staff awareness and was last seen at 1 p.m. sitting out front of the facility smoking. Police found him at a "friends" house and brought R1 back to the facility. Progress note dated 11/13/23 at 10:19 a.m., R1 eloped from facility. R1 was last seen at 9:45 a.m. sitting outside. Police department and guardian notified. Note at 11:50 a.m. indicated R1 returned to facility per self. The medical record did not contain any further elopement risk evaluations after 11/3/23, 11/11/23, and 11/13/23 elopements. Additionally, it was not evident further assessment was completed for R1's ability to smoke outside without supervision and/or evident R1's care plan revised with interventions to prevent R1 from eloping from the facility when smoking outside. Observation and interview on 11/14/23 at 1:25 p.m., R1 was ambulating in his room without the leg immobilizer on and swelling was noted to right knee and surrounding tissue. R1 stated he was going to "scrape up some money and walk to the gas station for cigarettes". R1 reported the facility took away the "sign out sheets" so he could not sign out anymore. R1 knew he was not supposed to leave the facility however felt like a "prisoner." Observation on 11/14/23 at 3:20 p.m., R1 was smoking outside on the patio independently without staff supervision.	F 689		

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F 689	Continued From page 5 Interview on 11/ 14/23 at 2:10 p.m., nursing assistant (NA)-A indicated R1 could smoke outside unsupervised. NA-A explained R1 frequently leaves the facility grounds from the designated smoking area. Interview on 11/14/23 at 2:15 p.m., NA-B indicated R1 leaves unsupervised to smoke quite often all day. R1 was supposed to leave his cigarettes and lighter at the desk but did not follow that rule so staff did not know when he went outside. Further indicated staff did not always know when R1 left the facility grounds. Interview on 11/14/23 at 2:18 p.m., NA-C was aware of R1 leaving the facility grounds and indicated he usually walked across town to get cigarettes or energy drinks and would return within a couple of hours. R1 fell and broke his leg and was no longer supposed to do that but he does. The staff "try to keep an eye out for him" but the facility did not have the staff to constantly supervise R1 smoking outside. Interview on 11/14/23 at 3:00 p.m., registered nurse (RN)-A indicated R1 was not safe to leave the facility grounds independently as he would walk down the middle of the road, cross the busy highway, and would rummage around town to bring back items to sell for cigarette money. Observation on 11/15/23 at 11:10 a.m., R1 was sitting on the seat of his walker on the outdoor patio smoking independently without staff supervision. Observation on 11/15/23 at 12:55 p.m. R1 on outdoor patio smoking independently without staff	F 689		

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F 689	Continued From page 6 supervision. Observation and interview on 11/15/23 at 1:25 p.m., R1 walked in from the patio after smoking straight past the nurse's station and did not turn in his cigarettes or lighter. Nursing assistant (NA)-B indicated all residents were supposed to turn their lighter, however R1 would not. Observation on 11/15/23 at 2:42 p.m., R1 was sitting outside on the sidewalk in front of building without supervision. R1 stood up and walked over to pick up a large outdoor ashtray without using his walker to move ashtray closer to him. R1 walked back into the facility at 2:55 p.m. and did not leave his lighter or cigarettes with staff. At 3:06 p.m. R1 walked back out to the patio to smoke without staff supervision. Interview on 11/15/23 at 2:45 p.m., NA-D, indicated no concerns about R1 smoking outside alone. NA-D indicated R1 would sometimes "walk off" and then staff would notify the charge nurse because they had their procedures to do. NA-D explained she did not constantly watch him while he was out smoking but would look out the windows when she walked by and periodically between caring for other residents. Interview on 11/15/23 at 1:00 p.m., RN-B indicated staff were aware R1 was going to go outside because because he would become anxious and start pacing. RN-B explained on 11/11/23, R1 was last seen about 1:15 p.m. to 1:30 p.m. but staff got busy with other residents. Staff noticed he was not outside anymore, the building was searched, and police were notified. R1 returned to the facility about 30-45 minutes	F 689		

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

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F 689	Continued From page 7 with the police officers. Interview on 11/15/23 at 3:12 p.m., RN-C indicated elopement assessments were done quarterly and after any elopement. Verified R1's most recent elopement assessment was completed with his annual assessment on 10/25/23. RN-C stated an elopement assessment should have been completed after R1's elopements on 11/3, 11/11, and 11/13. Interview on 11/15/23 at 1:35 p.m., director of nursing (DON) explained during one of R1's elopements, R1 went out to smoke, and he just took off. Further indicated R1 was not safe to go out in the community unsupervised because of the broken leg and lack of safety awareness. Staff tell him not to go but he yells and goes anyway. The DON indicated they were actively working on more appropriate placement options for R1. The DON indicated they do not have the staff to supervise him outside smoking as much as he goes out to smoke. Facility policy, Safety and Supervision of Residents, last reviewed 2/4/22, indicated the facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjust interventions accordingly. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined on the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. For	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 11/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 8 example, resident supervision may need to be increased when there are temporary hazards in the environment or if there is a change in the resident's condition.	F 689		