Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 11, 2024

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

RE: CCN: 245378
Cycle Start Date: August 27, 2024

Dear Administrator:

On August 27, 2024, 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 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 27, 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 February 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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September 11, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: PRHO11

Dear Administrator:

The above facility was surveyed on August 26, 2024 through August 27, 2024 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, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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 08/27/2024

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 8/26/24, and 8/27/24, 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. H53787340C (MN00106010, MN00106023, MN00106027). As a result of the investigation a deficiency was issued 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	F 689		9/16/24

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

Electronically Signed | 09/13/2024

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 by: Based on observation, interview and record review the facility failed to comprehensively assess and provide an adequate plan for supervision and appropriate interventions to protect, respect and promote rights of the resident to meet individual needs, for 1 of 3 residents (R1) reviewed for elopement. Additionally, the facility failed to ensure 1 of 1 (R1) resident care plans were revised and staff were aware of interventions to maintain resident safety. Findings include: R1's admission Minimum Data Set dated 5/29/24, identified intact cognition with no behaviors. R1 was independent with toileting and oral hygiene, eating, transfers, and ambulation. R1 required supervision with shower/bath, upper and lower dressing, and personal hygiene. R1 was continent of bowel and bladder. R1's diagnoses included: coronary artery disease (CAD), atrial fibrillation (AFIB), benign prostatic hyperplasia (BPH) (enlarged prostate causes obstructive urinary flow), and obstructive uropathy. R1 required no wander guard or alarms. R1's Care Area Assessment (CAA) dated 6/5/24, identified cognitive skills required for daily decision making and possible underlying problems that may have affected R1's cognitive function were identified as changing cognitive status, poor memory, mood decline, vision problems, and depression. R1's care plan last updated on 8/21/24, identified high risk for elopement or wandering. Goal: safety would be maintained through the review date.	F 689	R 1 was located, evaluated by the local hospital team and returned unharmed to the facility. A new elopement assessment was completed, a wander guard was applied, and the elopement care plan updated as needed. A risk management incident was created, and root cause identified. All existing residents who are at risk for elopement, their care plans and assessments were reviewed and updated as needed. Future residents who are admitted to the facility and are at risk for elopement will have their elopement assessment completed, wander guard placed and care plan with individualized interventions added. Facility staff reviewed the Elopement Policy and was in-serviced on the Safety and Supervision of Residents when emphasis of creating person-centered interventions to reduce risks, supervision and assistive devices. Director of Nursing and/or designee is responsible for compliance. Audits on resident elopement assessment completion, if supervision is per care plan being followed and person-centered care plan interventions for elopement and wandering will begin 2x week x 3 weeks, weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be given to the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance 9/16/2024	

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F 689	Continued From page 2 Staff were directed to assess elopement status quarterly and as needed, identify pattern of wandering (purposeful, aimless, or escapist), looking for something, or need for more exercise, and intervene as appropriate. R1's wander alert device was applied to left wrist on 8/21/24, expired 90 days, and added to EMAR for changing device. R1's Kardex dated 8/26/24, identified assess elopement status quarterly and as needed. R1 required prompt responses to all requested for assistance and wander alert devised applied to left wrist 8/21/24, expired 90 days, cue added to EMAR for changing device. R1's care plan and Kardex lacked staff interventions to ensure adequate supervision was provided. R1's care plan last updated on 8/27/24, identified R1 was an elopement risk and required supervision while outdoors due to elopement risk. R1's Elopement Assessment dated 5/23/24, identified R1 was ambulatory and had diagnoses of OBS (organic brain syndrome), dementia, psychosis, Alzheimer's, or other psychiatric diagnosis. R1 was identified as a low risk for elopement. Interventions selected: frequent monitoring, staff made aware of elopement risk, personalization of room (pictures, familiar items). R1's Elopement Assessment dated 8/21/24, identified R1 had a history of elopement or an attempted elopement and remained at risk. Clinical suggestions identified: apply personal safety alarm device, notify staff of elopement risk, and monitor location frequency.	F 689		

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F 689	Continued From page 3 R1's Brief Interview for Mental Status (BIMS) evaluation dated 8/22/24, identified cognition remained intact but had slightly decreased from a score of 15 to a 12 (range 13 to 15 cognitively intact). R1's primary provider/Doctor of Osteopathic Medicine (DO) (focus on holistic health and prevention) visit dated 8/23/24, identified cognitive decline/change in behavior. Single episode of elopement/wandering and unsure why he left. R1 does not have a diagnosis of dementia but had demonstrated some cognitive decline. Plan: blood work ordered CBC (complete metabolic panel), CBC (complete blood count), TSH (thyroid stimulating hormone) for evaluation of organic causes, had no genitourinary symptoms, held off on UA (urinalysis), and Neuropsychiatric testing for further evaluation of dementia. R1's Social Service Resident Vulnerability and Susceptibility to Abuse completed on 8/25/24, identified cognitive impairment, easily exploited by others, and sensory impairment. R1's Psychosocial Quarterly -V7 completed on 8/25/24, identified R1 declined mental health services and felt they were not needed. Family discussed possible need. R1's had someone who assisted with financial and healthcare decisions. R1 was able to make some decisions on his own. R1's cognition was identified as declined and Neuropsychiatric appointment recommended. Summary: no concerns with R1's BIMS score however believed with recent incident, and inability to recollect, a Neuropsychiatric visit may/should be recommended. R1's family in	F 689		

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F 689	Continued From page 4 room indicated they wished to discuss this further. R1 was unable to recall recent wander incident and denied why he left. Writer believed although PHQ (patient health questionnaire) (a multipurpose instrument used for screening, diagnosing, monitoring, and measuring severity of depression) scores were good, mental health services for even short term would be beneficial. R1's progress notes on 8/21/24, identified: -4:41 p.m. R1 eloped from the facility today was seen leaving on camera from front entrance at 8:22 a.m. facility was searched, resident not found, local law enforcement called to assist. R1's daughter arrived shortly after the elopement. R1 had brought his jacket, a hat, and gloves. He stated upon return he had planned to stay overnight. Officers located him and brought him back to facility to be evaluated. R1 was found to be unharmed, wander guard was put in place for safety and staff initiated every 15-minute checks for the first 24 hours of his return. Tools and scissors were removed from resident room for safety. -at 11:14 p.m. R1 returned from emergency room this afternoon and a wander guard was placed on left wrist. Education was given to R1, his wife (F-A) (also resident at the facility), and daughter (F-B) regarding wander guard. They verbalized their understanding of the device and reason for use. During an observation/interview on 8/26/24 at 2:57 p.m., R1 and F-A (also resident) sat in recliners in bedroom together with the door closed. R1 stated he wandered away from the facility, but not sure why. R1 indicated he saw a	F 689		

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F 689	Continued From page 5 big tree, felt tired, heart ticked fast, and thought it would be a good place to rest. R1 stated the tree was located by some water but he was unsure if was a river, lake, or pond, adding his memory had not been good for three to five years now and he knew everyone thought he was crazy. R1 also stated he was aware he should not have left but he grabbed a cap, jacket, two cans of root beer, and planned to stay over night, "so that was what he did". Adding, he sat by the tree, saw the water and that is where he would have gone in the morning to get out of here but "they caught me be before that happened". R1 indicated he thought he was gone one and half days. During an observation/interview on 8/27/24 at 9:50 a.m., R1 and F-A sat in recliners in bedroom together with door closed. R1's F-A stated was too hot to go outside and sit so they had chosen to stay in their room together. During an interview on 8/26/24 at 1:45 p.m., nursing assistant (NA)-A stated R1 and F-A had argued the morning of 8/21/24, F-A later informed her she could not find R1 after breakfast, thought he just wanted time by himself. NA-A stated R1 had dementia, but F-A had always been the leader and directed him. NA-A notified charge nurse, search of premises (inside and outside) was completed, and police department notified. NA-A stated R1 was found and taken to the emergency department (ED). NA-A stated the next day R1 had on a wander guard and was not allowed to be outside by himself and required supervision by either F-A or staff. NA-A stated they usually looked in resident's Kardex or care plan in the electronic medical record if unsure how to care for them.	F 689		

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F 689	Continued From page 6 During an interview on 8/26/24 at 2:07 p.m., NA-B stated R1 had dementia, poor memory, required cues, and F-A provided reminders. NA-B started mostly R1's long term memory seemed to be affected and wore a wander guard. NA-B stated R1 and his wife (F-A) were always together and very unusual for him to leave the building alone that day. Since R1's elopement, NA-B stated staff were directed to entered the door code so that R1 and F-A could go outside together. NA-A indicated R1 was not allowed to go out my himself anymore and must have either F-A, his family, or staff with him. During an interview on 8/26/24 at 3:35 p.m., registered nurse (RN)-A stated it was very unusual for R1 to leave building without his F-A and was now a high risk for wandering or elopement. RN-A verified she had applied the wander guard to R1's wrist once he returned from ED on 8/21/24. RN-A stated when R1 asked if he could go outside she would have to explained to him, F-A and F-B that staff will need to enter the code on the door so he can go outside with either F-A, staff or other family. RN-A indicated R1 required supervision when outside and should still be supervised by staff from inside the building. RN-A stated she hoped staff were informed and aware of that; she then checked the point click care (PCC) communication board and nothing had been placed on there and explained she felt too many little things were being missed. RN-A indicated she had informed R1's wife (F-A) if he started to get up and walked away, she needed to come back inside the building and ask staff for assistance. During an interview on 8/27/24 at 10:00 a.m., F-A stated R1 had talked about walking in the corn	F 689		

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F 689	Continued From page 7 fields months ago to "get lost". F-A verified she felt awful, laid awake at night with thoughts of if she would not have drank an extra cup of coffee that morning, she could have prevented all of this by going back to the room with him, and possibly stopped him from leaving. F-A stated she was ok with being alone outside with him, knew what to do when he started to walk away or refused to come back in, then got tears in her eyes and paused for a moment. F-A indicated she was informed by staff to ring doorbell outside when he started to walk away. F-A then stated she just hoped staff answered the doorbell right away because R1 moved rather fast at times. F-A also indicated R1's memory had gotten worse and she never told staff, but she had tried helping him as much as she could. During an interview on 8/27/24 at 10:30 a.m., NA-C indicated R1 had told her he felt more forgetful lately and was frustrated by that. NA-C stated R1 usually stayed close to F-A so his elopement was very unexpected. NA-C stated she was unsure if R1 had a wander guard on, but he had been outside with F-A many times since the elopement incident. NA-C stated residents on the patio outside were observed by staff from inside the building but R1 was allowed to go out with F-A. NA-C stated R1's interventions had not changed since incident. NA-C stated they had checked the plan of care weekly which identified how to care for each resident. NA-C stated residents were required to let staff know when they wanted to go outside, that was it. During an interview on 8/27/24 at 10:45 a.m., licensed practical nurse (LPN)-A stated R1 staff relied on shift report and resident Kardex to identify interventions. LPN-A verified R1's care	F 689		

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F 689	Continued From page 8 plan identified a wander guard was in placed, but did not detail any other plans. LPN-A stated R1 required supervision outside from either F-A, family or staff through the window or if staff went outside with him. LPN-A stated they were not able to rely on shift report due to turn over. LPN-A also indicated concern related to staffing plan to watch R1 from inside as it was unlikely someone was always located at the front door or could respond to the doorbell quickly. LPN-A stated R1's cognition was not intact and was unable to decide about psych evaluations. LPN-A indicated it had appeared more difficult for F-A to intervene with him, as he did not always respond well to her, or she got upset with him and he was able to walk a lot a lot faster than her so if he left the property, by the time she located help, he could already be pretty far away. LPN-A stated F-B had mentioned this last week also adding the facility courtyard was a contained area, not being used by residents, and would be more appropriate area for R1 and his wife (F-A) to sit outside in. During an interview on 8/27/24 at 11:30 a.m., social worker (SW) stated she visited with R1 and family last weekend and recommended a neuro/psych consult after R1 eloped. SW stated R1 was confused as to why he left the facility alone and the family was considering mental health services. SW indicated R1 must be supervised to go outside, and confirmed F-A's supervision would not be enough. SW indicated if R1 walked off when outside and F-A had to go inside the building to find help, by that time he could have been half way across the road and possibly hit by a car. SW stated R1 moved a lot faster than F-A. SW stated that if she looked at this from the outside in, it did not seem to be the most appropriate action or plan. SW also stated	F 689		

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F 689	Continued From page 9 she did not think F-A could bare all of that responsibility, being vulnerable herself. SW stated R1's cognition had declined relativity rapidly and his recollection was worse than when admitted. SW stated the BIMS was not a true assessment of cognitive abilities and a neuro/psych evaluation was recommended. SW verified R1's family wanted time to discuss among themselves if R1 would have benefited from mental health services. SW stated any resident with a wander guard should be supervised especially outside and included in their interventions on the care plan to be safe. SW verified the facility courtyard (contained outside area) was not used due to side walks where unleveled and deemed a safety risk. During an interview on 8/27/24 at 1:25 p.m., assistant director of nursing (ADON) stated R1's family just agreed to a neuro/psych evaluation, which was ordered, and needed to get scheduled. ADON indicated SW met with R1 on Sunday and was able to answer orientation questions but unable to track past experiences. ADON stated R1 had long and short-term memory loss, BIMS was not the most accurate assessment of R1's cognition, and seemed to fluctuate, possibly some sundown (group of symptoms people with dementia experience afternoon and early evening such as confusion, trouble sleeping, anxiety, wandering, and hallucinations) may have occurred also. ADON indicted R1's incident was pretty unexpected, with no past occurrences of leaving the facility grounds and never walked without F-A. ADON indicated after the elopement, a wander guard was applied and every 15-minute checks for first 24 hours was completed. ADON stated R1 was not declared a high risk for elopement. ADON stated R1 was required to	F 689		

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F 689	Continued From page 10 have supervision of staff when outside and his wife does not count as a person that could have supervised him because she was a resident of the facility herself. ADON verified a resident can not be allowed to supervise another resident, staff were not trained to do this. ADON stated F-A was not capable to have supervised R1 outside, had occasional forgetfulness, and unable to chase after him with a walker due to her high risk for falls. ADON indicated R1's level of supervision required by staff should have been listed on the care plan under interventions, thought about that this morning, and added to the R1's care plan today. ADON stated R1's supervision level required him to be where staff were able to visualize him and not assumed the staff just knew about this. During an interview on 8/24/24 at 2:01 p.m., director of nursing (DON) stated R1 was allowed to go alone outside with F-A, adding F-A supervises him in her own way as she has watched over him for over 70 years. DON went on to state that R1 was not officially supervised by F-A because he was his own person and she was aware of him being outside with her. DON stated F-A was expected to alert staff when he had decided to stay outside without her, because he could wander off down the road, and that would be a safety issue for sure. DON indicated staff were aware they were outside, watched them from inside through the window, relayed that to other staff if they had to step away. DON indicated F-A took on the supervisory roll herself, was not assigned to her, and an assessment had not completed to be in charge of R1. DON stated R1 and F-A were both equally here, required to be taken care by staff, as a couple required time to be together, and did not want her to be	F 689		

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F 689	Continued From page 11 stressed out. DON stated staff were expected to have reviewed resident's care plan and/or Kardex, 24-hour report book, and receive shift change report during their shift. DON indicated R1's care plan should have included special supervision interventions so that all staff were made aware for his safety. Facility policy Care Planning - Interdisciplinary Team last reviewed 11/30/21, identified the facility's care planning/interdisciplinary team was responsible for development and revisions of an individualized comprehensive care plan for each resident. Facility policy Care Plans, Comprehensive Person-Centered last reviewed 11/30/21, identified a comprehensive, person-centered care plan includes measurable objectives and timetables to have met the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The care planning process would incorporate interventions that were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Facility policy Safety and Supervision of Residents last reviewed 2/4/22, facility strives to provide an environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents were the facility-wide priorities. The care team should have targeted interventions to reduce risks related to hazards in the environment, which included adequate supervision and assistive devices. Specific interventions are to be communicated to all relevant staff, training provided, assigned responsibility to have	F 689		

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F 689	Continued From page 12 interventions carried out, ensure interventions were implemented, and evaluated for effectiveness.	F 689		

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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 8/26/24, and 8/27/24, complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53787340C (MN00106010, MN00106023, MN00106027). As a result of the investigation a licensing order was issued at 0880. 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	2 000		

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2 000	Continued From page 2 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. 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		
2 880	MN Rule 4658.0520 Subp. 2 J Adequate and Proper Nursing Care; Wt & height Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: J. Recording resident height and weight at the time of admission and weight at least monthly thereafter. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively assess and provide an adequate plan for supervision and appropriate interventions to protect, respect and promote rights of the resident to meet individual needs, for 1 of 3 residents (R1) reviewed for elopement. Additionally, the facility failed to ensure 1 of 1 (R1) resident care plans were revised and staff were aware of interventions to maintain resident safety. Findings include:	2 880	Corrected	9/16/24

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2 880	Continued From page 3 R1's admission Minimum Data Set dated 5/29/24, identified intact cognition with no behaviors. R1 was independent with toileting and oral hygiene, eating, transfers, and ambulation. R1 required supervision with shower/bath, upper and lower dressing, and personal hygiene. R1 was continent of bowel and bladder. R1's diagnoses included: coronary artery disease (CAD), atrial fibrillation (AFIB), benign prostatic hyperplasia (BPH) (enlarged prostate causes obstructive urinary flow), and obstructive uropathy. R1 required no wander guard or alarms. R1's Care Area Assessment (CAA) dated 6/5/24, identified cognitive skills required for daily decision making and possible underlying problems that may have affected R1's cognitive function were identified as changing cognitive status, poor memory, mood decline, vision problems, and depression. R1's care plan last updated on 8/21/24, identified high risk for elopement or wandering. Goal: safety would be maintained through the review date. Staff were directed to assess elopement status quarterly and as needed, identify pattern of wandering (purposeful, aimless, or escapist), looking for something, or need for more exercise, and intervene as appropriate. R1's wander alert device was applied to left wrist on 8/21/24, expired 90 days, and added to EMAR for changing device. R1's Kardex dated 8/26/24, identified assess elopement status quarterly and as needed. R1 required prompt responses to all requested for assistance and wander alert devised applied to left wrist 8/21/24, expired 90 days, cue added to EMAR for changing device.	2 880		

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2 880	Continued From page 4 R1's care plan and Kardex lacked staff interventions to ensure adequate supervision was provided. R1's care plan last updated on 8/27/24, identified R1 was an elopement risk and required supervision while outdoors due to elopement risk. R1's Elopement Assessment dated 5/23/24, identified R1 was ambulatory and had diagnoses of OBS (organic brain syndrome), dementia, psychosis, Alzheimer's, or other psychiatric diagnosis. R1 was identified as a low risk for elopement. Interventions selected: frequent monitoring, staff made aware of elopement risk, personalization of room (pictures, familiar items). R1's Elopement Assessment dated 8/21/24, identified R1 had a history of elopement or an attempted elopement and remained at risk. Clinical suggestions identified: apply personal safety alarm device, notify staff of elopement risk, and monitor location frequency. R1's Brief Interview for Mental Status (BIMS) evaluation dated 8/22/24, identified cognition remained intact but had slightly decreased from a score of 15 to a 12 (range 13 to 15 cognitively intact). R1's primary provider/Doctor of Osteopathic Medicine (DO) (focus on holistic health and prevention) visit dated 8/23/24, identified cognitive decline/change in behavior. Single episode of elopement/wandering and unsure why he left. R1 does not have a diagnosis of dementia but had demonstrated some cognitive decline. Plan: blood work ordered CBC (complete metabolic panel), CBC (complete blood count),	2 880		

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2 880	Continued From page 5 TSH (thyroid stimulating hormone) for evaluation of organic causes, had no genitourinary symptoms, held off on UA (urinalysis), and Neuropsychiatric testing for further evaluation of dementia. R1's Social Service Resident Vulnerability and Susceptibility to Abuse completed on 8/25/24, identified cognitive impairment, easily exploited by others, and sensory impairment. R1's Psychosocial Quarterly -V7 completed on 8/25/24, identified R1 declined mental health services and felt they were not needed. Family discussed possible need. R1's had someone who assisted with financial and healthcare decisions. R1 was able to make some decisions on his own. R1's cognition was identified as declined and Neuropsychiatric appointment recommended. Summary: no concerns with R1's BIMS score however believed with recent incident, and inability to recollect, a Neuropsychiatric visit may/should be recommended. R1's family in room indicated they wished to discuss this further. R1 was unable to recall recent wander incident and denied why he left. Writer believed although PHQ (patient health questionnaire) (a multipurpose instrument used for screening, diagnosing, monitoring, and measuring severity of depression) scores were good, mental health services for even short term would be beneficial. R1's progress notes on 8/21/24, identified: -4:41 p.m. R1 eloped from the facility today was seen leaving on camera from front entrance at 8:22 a.m. facility was searched, resident not found, local law enforcement called to assist. R1's daughter arrived shortly after the elopement. R1 had brought his jacket, a hat, and gloves. He	2 880		

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2 880	Continued From page 6 stated upon return he had planned to stay overnight. Officers located him and brought him back to facility to be evaluated. R1 was found to be unharmed, wander guard was put in place for safety and staff initiated every 15-minute checks for the first 24 hours of his return. Tools and scissors were removed from resident room for safety. -at 11:14 p.m. R1 returned from emergency room this afternoon and a wander guard was placed on left wrist. Education was given to R1, his wife (F-A) (also resident at the facility), and daughter (F-B) regarding wander guard. They verbalized their understanding of the device and reason for use. During an observation/interview on 8/26/24 at 2:57 p.m., R1 and F-A (also resident) sat in recliners in bedroom together with the door closed. R1 stated he wandered away from the facility, but not sure why. R1 indicated he saw a big tree, felt tired, heart ticked fast, and thought it would be a good place to rest. R1 stated the tree was located by some water but he was unsure if was a river, lake, or pond, adding his memory had not been good for three to five years now and he knew everyone thought he was crazy. R1 also stated he was aware he should not have left but he grabbed a cap, jacket, two cans of root beer, and planned to stay over night, "so that was what he did". Adding, he sat by the tree, saw the water and that is where he would have gone in the morning to get out of here but "they caught me be before that happened". R1 indicated he thought he was gone one and half days. During an observation/interview on 8/27/24 at 9:50 a.m., R1 and F-A sat in recliners in bedroom together with door closed. R1's F-A stated was	2 880		

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2 880	Continued From page 7 too hot to go outside and sit so they had chosen to stay in their room together. During an interview on 8/26/24 at 1:45 p.m., nursing assistant (NA)-A stated R1 and F-A had argued the morning of 8/21/24, F-A later informed her she could not find R1 after breakfast, thought he just wanted time by himself. NA-A stated R1 had dementia, but F-A had always been the leader and directed him. NA-A notified charge nurse, search of premises (inside and outside) was completed, and police department notified. NA-A stated R1 was found and taken to the emergency department (ED). NA-A stated the next day R1 had on a wander guard and was not allowed to be outside by himself and required supervision by either F-A or staff. NA-A stated they usually looked in resident's Kardex or care plan in the electronic medical record if unsure how to care for them. During an interview on 8/26/24 at 2:07 p.m., NA-B stated R1 had dementia, poor memory, required cues, and F-A provided reminders. NA-B started mostly R1's long term memory seemed to be affected and wore a wander guard. NA-B stated R1 and his wife (F-A) were always together and very unusual for him to leave the building alone that day. Since R1's elopement, NA-B stated staff were directed to entered the door code so that R1 and F-A could go outside together. NA-A indicated R1 was not allowed to go out my himself anymore and must have either F-A, his family, or staff with him. During an interview on 8/26/24 at 3:35 p.m., registered nurse (RN)-A stated it was very unusual for R1 to leave building without his F-A and was now a high risk for wandering or elopement. RN-A verified she had applied the	2 880		

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	00731	A. BUILDING: _____ B. WING _____	C 08/27/2024

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2 880	Continued From page 8 wander guard to R1's wrist once he returned from ED on 8/21/24. RN-A stated when R1 asked if he could go outside she would have to explained to him, F-A and F-B that staff will need to enter the code on the door so he can go outside with either F-A, staff or other family. RN-A indicated R1 required supervision when outside and should still be supervised by staff from inside the building. RN-A stated she hoped staff were informed and aware of that; she then checked the point click care (PCC) communication board and nothing had been placed on there and explained she felt too many little things were being missed. RN-A indicated she had informed R1's wife if he started to get up and walked away, she needed to come back inside the building and ask staff for assistance. During an interview on 8/27/24 at 10:00 a.m., F-A stated R1 had talked about walking in the corn fields months ago to "get lost". F-A verified she felt awful, laid awake at night with thoughts of if she would not have drank an extra cup of coffee that morning, she could have prevented all of this by going back to the room with him, and possibly stopped him from leaving. F-A stated she was ok with being alone outside with him, knew what to do when he started to walk away or refused to come back in, then got tears in her eyes and paused for a moment. F-A indicated she was informed by staff to ring doorbell outside when he started to walk away. F-A then stated she just hoped staff answered the doorbell right away because R1 moved rather fast at times. F-A also indicated R1's memory had gotten worse and she never told staff, but she had tried helping him as much as she could. During an interview on 8/27/24 at 10:30 a.m., NA-C indicated R1 had told her he felt more	2 880		

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2 880	Continued From page 9 forgetful lately and was frustrated by that. NA-C stated R1 usually stayed close to F-A so his elopement was very unexpected. NA-C stated she was unsure if R1 had a wander guard on, but he had been outside with F-A many times since the elopement incident. NA-C stated residents on the patio outside were observed by staff from inside the building but R1 was allowed to go out with F-A. NA-C stated R1's interventions had not changed since incident. NA-C stated they had checked the plan of care weekly which identified how to care for each resident. NA-C stated residents were required to let staff know when they wanted to go outside, that was it. During an interview on 8/27/24 at 10:45 a.m., licensed practical nurse (LPN)-A stated R1 staff relied on shift report and resident Kardex to identify interventions. LPN-A verified R1's care plan did not identified a wander guard was in placed, or that R1 required supervision outside from either F-A, family or staff through the window or if staff went outside with him. LPN-A stated they were not able to rely on shift report due to turn over. LPN-A also indicated concern related to staffing plan to watch R1 from inside as it was unlikely someone was always located at the front door or could respond to the doorbell quickly. LPN-A stated R1's cognition was not intact and was unable to decide about psych evaluations. LPN-A indicated it had appeared more difficult for F-A to intervene with him, as he did not always respond well to her, or she got upset with him and he was able to walk a lot a lot faster than her so if he left the property, by the time she located help, he could already be pretty far away. LPN-A stated F-B had mentioned this last week also adding the facility courtyard was a contained area, not being used by residents, and would be more appropriate area for R1 and his	2 880		

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2 880	Continued From page 10 wife (F-A) to sit outside in. During an interview on 8/27/24 at 11:30 a.m., social worker (SW) stated she visited with R1 and family last weekend and recommended a neuro/psych consult after R1 eloped. SW stated R1 was confused as to why he left the facility alone and the family was considering mental health services. SW indicated R1 must be supervised to go outside, and confirmed F-A's supervision would not be enough. SW indicated if R1 walked off when outside and F-A had to go inside the building to find help, by that time he could have been half way across the road and possibly hit by a car. SW stated R1 moved a lot faster than F-A. SW stated that if she looked at this from the outside in, it did not seem to be the most appropriate action or plan. SW also stated she did not think F-A could bare all of that responsibility, being vulnerable herself. SW stated R1's cognition had declined relativity rapidly and his recollection was worse than when admitted. SW stated the BIMS was not a true assessment of cognitive abilities and a neuro/psych evaluation was recommended. SW verified R1's family wanted time to discuss among themselves if R1 would have benefited from mental health services. SW stated any resident with a wander guard should be supervised especially outside and included in their interventions on the care plan to be safe. SW verified the facility courtyard (contained outside area) was not used due to side walks where unleveled and deemed a safety risk. During an interview on 8/27/24 at 1:25 p.m., assistant director of nursing (ADON) stated R1's family just agreed to a neuro/psych evaluation, which was ordered, and needed to get scheduled. ADON indicated SW met with R1 on Sunday and	2 880		

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2 880	Continued From page 11 was able to answer orientation questions but unable to track past experiences. ADON stated R1 had long and short-term memory loss, BIMS was not the most accurate assessment of R1's cognition, and seemed to fluctuate, possibly some sundown (group of symptoms people with dementia experience afternoon and early evening such as confusion, trouble sleeping, anxiety, wandering, and hallucinations) may have occurred also. ADON indicted R1's incident was pretty unexpected, with no past occurrences of leaving the facility grounds and never walked without F-A. ADON indicated after the elopement, a wander guard was applied and every 15-minute checks for first 24 hours was completed. ADON stated R1 was not declared a high risk for elopement. ADON stated R1 was required to have supervision of staff when outside and his wife does not count as a person that could have supervised him because she was a resident of the facility herself. ADON verified a resident can not be allowed to supervise another resident, staff were not trained to do this. ADON stated F-A was not capable to have supervised R1 outside, had occasional forgetfulness, and unable to chase after him with a walker due to her high risk for falls. ADON indicated R1's level of supervision required by staff should have been listed on the care plan under interventions, thought about that this morning, and added to the R1's care plan today. ADON stated R1's supervision level required him to be where staff were able to visualize him and not assumed the staff just knew about this. During an interview on 8/24/24 at 2:01 p.m., director of nursing (DON) stated R1 was allowed to go alone outside with F-A, adding F-A supervises him in her own way as she has watched over him for over 70 years. DON went	2 880		

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2 880	Continued From page 12 on to state that R1 was not officially supervised by F-A because he was his own person and she was aware of him being outside with her. DON stated F-A was expected to alert staff when he had decided to stay outside without her, because he could wander off down the road, and that would be a safety issue for sure. DON indicated staff were aware they were outside, watched them from inside through the window, relayed that to other staff if they had to step away. DON indicated F-A took on the supervisory roll herself, was not assigned to her, and an assessment had not completed to be in charge of R1. DON stated R1 and F-A were both equally here, required to be taken care by staff, as a couple required time to be together, and did not want her to be stressed out. DON stated staff were expected to have reviewed resident's care plan and/or Kardex, 24-hour report book, and receive shift change report during their shift. DON indicated R1's care plan should have included special supervision interventions so that all staff were made aware for his safety. Facility policy Care Planning - Interdisciplinary Team last reviewed 11/30/21, identified the facility's care planning/interdisciplinary team was responsible for development and revisions of an individualized comprehensive care plan for each resident. Facility policy Care Plans, Comprehensive Person-Centered last reviewed 11/30/21, identified a comprehensive, person-centered care plan includes measurable objectives and timetables to have met the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The care planning process would incorporate interventions that were derived from a thorough	2 880		

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2 880	Continued From page 13 analysis of the information gathered as part of the comprehensive assessment. Facility policy Safety and Supervision of Residents last reviewed 2/4/22, facility strives to provide an environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents were the facility-wide priorities. The care team should have targeted interventions to reduce risks related to hazards in the environment, which included adequate supervision and assistive devices. Specific interventions are to be communicated to all relevant staff, training provided, assigned responsibility to have interventions carried out, ensure interventions were implemented, and evaluated for effectiveness. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 880		