DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL38580001M
Compliance #: HL38580002C

Date Concluded: March 2, 2022

Name, Address, and County of Licensee Investigated:
Valley View Estates of Long Prairie
1104 4th Avenue Northeast
Long Prairie, MN 56347
Todd County

Facility Type: Unlicensed Facility

Evaluator's Name: Michele R. Larson
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: The facility neglected the resident after the resident experienced facial bruises and two broken teeth of an unknown origin.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. There were conflicting reports of how and when the resident sustained his injuries. Staff were unaware of how the injury occurred, even though the resident received hourly safety checks. Nursing staff failed to reassess the resident after he sustained his injuries. Employee training records lacked evidence staff demonstrated competencies before providing cares for the resident. Staff were not retrained after the incident. The facility did not conduct an internal investigation.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident's family members. The investigation included review of entire resident's medical record, incident reports,

employee training records, and policies and procedures. In addition, the investigator reviewed the resident's hospital record, and police report.. The investigator observed staff assisting with resident cares, including walking, transfers, and meals.

The resident lived in the facility's memory care unit. The resident's diagnoses included Down Syndrome, sub-dural hematoma, craniotomies, and moderate malnutrition. The resident was wheelchair bound and required assistance with all personal cares; including two-person transfers using a mechanical lift device, toileting, catheter cares, feeding, and repositioning. In addition, the resident received physical therapy and catheter changes from a local home health agency. The resident was mostly non-verbal and communicated with some sign language and gestures.

Late one morning, family member #1 (FM #1), received a phone call from the facility registered nurse (RN). The RN told FM #1 staff found a "light shadow bruise" and "red dots" by the resident's left eyebrow and outer eye area. The RN told FM #1, the resident's eye did not appear to be injured. The RN told FM #1, staff did not know how the resident sustained the injuries. When FM #2 arrived at the facility, she noticed the bruise was yellow in color, appearing to be an older bruise, and not what was described to her by the RN. FM #2 also observed the red dots and swelling on the resident's eye lid and outer eye area. FM #2 noticed the resident had two upper broken teeth that were previously intact during her visit the week before. FM #1 and FM #2 transported the resident to the local emergency department to be evaluated.

Hospital records indicated the resident experienced bruising to his upper left eyebrow, descending to his eye lid. The hospital record indicated the resident grimaced when his left upper arm was touched. After a few hours at the hospital, the resident was discharged back to the facility.

The resident's incident report indicated the RN noticed petechiae (small red, purple dots) and bruising around the resident's left eyebrow and eye. The incident report indicated the RN wrote the resident wore glasses. The incident report indicated family was notified but 911 was not called. The incident report indicated the RN and administrator interviewed staff to find out what happened.

The resident's medical record lacked evidence an internal investigation was conducted.

The resident's medical record indicated the RN failed to perform a reassessment on the resident after his discharge from the hospital or implement interventions to prevent future incidents from occurring again. The resident's individual abuse prevention plan was not updated after the resident's discharge from the hospital. No documentation was provided indicating staff were reeducated after the incident.

The resident's safety checklist indicated an unlicensed personnel (ULP)-B falsely documented she performed checks on the resident during the time the resident was at the hospital.

The facility's personnel training records indicated the RN failed to ensure ULP were properly trained and demonstrated competency in a practical skills test using the mechanical lift device and transferring the resident.

During an interview, the physical therapist (PT), stated they were not immediately notified by the facility regarding the resident's injuries. The PT stated the family notified them two weeks after the incident. The PT stated she did not think the resident received the cares he needed due to the facility being short staffed. The PT stated she was concerned when the facility told the resident's family his injuries occurred during repositioning in bed. PT stated this story, "didn't add up," stating it was unusual for someone to receive that type of injury while being repositioned. PT stated she thought his injury may have occurred during the incorrect use of the mechanical lift device, stating if the straps are not adjusted correctly the resident could easily slide out of the device. The PT stated, there had been ongoing concerns about staff using the mechanical lift correctly.

A provided text message between FM #2 and ULP-E, indicated ULP-E saw the resident's facial bruises four days before the injury was reported to FM #1 and FM #2.

During an interview, FM #1 stated ULP-E stated the resident looked like a "mess." FM #1 stated ULP-E told him the administrator put out a work text message to staff, asking them if the resident was dropped. FM #1 stated he and FM #2 reached out to the administrator several times but never received a reply, stating it was not uncommon for the administrator to not respond to their phone calls or messages. FM #1 stated they had concerns about the resident's cares prior to this incident. FM #1 stated there were no staff interactions with the resident when he and FM #2 visited. FM #1 stated sometimes they would find the resident sitting in the communal area, unkept, with food all over his face. FM #1 stated he and FM #2 had a care conference with the administrator and RN regarding the resident's cares. A care plan was implemented to ensure the resident' cares were performed on a regular basis. FM #1 stated the administrator would tell him he "forgot" to put a service on the resident's schedule, or staff would tell them the resident had a bath when it was clear the resident did not receive one. FM #1 stated, "they [facility management] would recognize the mistake" but did not put interventions in place.

During an interview, FM #2 stated staff's stories kept changing. FM #2 stated ULP-F suggested the resident "scratched" his left eye. FM #2 stated the administrator told her, "we're thinking it happened when he rolled over in bed," telling FM #2 the resident "might have" been wearing his eyeglasses during repositioning and cares, but was unsure. FM #2 stated she could tell the resident's facial injuries did not happen the day before. FM #2 stated there were many visits where she performed the cares for the resident, stating staff ignored him when she was there.

During an interview, ULP-E stated he immediately noticed the resident's facial injuries during the resident's morning cares days before the resident's injuries were reported to his family. ULP-E stated when he saw the resident he asked, "what the heck happened?" ULP-E stated the resident previously slept with his eyeglasses on and stated the resident never was bruised after wearing his eyeglasses in bed. ULP-E stated he immediately reported the resident's injuries to the administrator and RN. ULP-E stated he witnessed ULP-B documenting cares were provided when they were never completed. ULP-E stated he talked to the administrator and RN about the safety and well-being of the residents whenever ULP-B worked, telling them something needed to be done.

During an interview, ULP-F stated she saw ULP-B and another ULP attempting to pick the resident up underneath his arms during a transfer from his wheelchair to his bed. ULP-F stated she told ULP-B and the other ULP to use the mechanical lift device. ULP-F stated she had minimal training when she was hired. ULP-F stated her floor training lasted two days. ULP-F stated the first day she observed resident cares, and the second day she performed resident cares on her own.

During an interview, the administrator stated he needed to get information from staff and nurses when he first saw the resident's facial bruises. The administrator stated the resident's bruises were a "different" color than what was expected for a new bruise, stating the bruised looked faded. The administrator stated he was troubled when he did not find an incident report. The administrator stated he and the RN decided the resident's injuries were caused from staff rolling him during cares, stating, "it was our best educated guess." The administrator stated he and the RN verbally talked to staff to always use the mechanical lift device using two staff members. The administrator stated he recalled when a ULP told him that resident cares and cleaning were not being done in the memory care unit. The administrator stated he and the RN talked to ULP-B after ULP-E came to them with concerns that ULP-B was not providing resident cares and they talked to ULP-B.

During an interview, the RN stated staff told her about the resident's eye injury the morning his family took him to the hospital to be evaluated. The RN stated staff were not aware of any injury that occurred. The RN stated it appeared to her the resident's injuries were caused by staff rolling the resident on his side during repositioning. The RN stated the resident's left eye appeared to be "without injury." The RN stated she talked to staff to see if they had his eyeglasses on and rolled him in his bed during cares, stating his eyeglasses may have pushed into his face when they rolled him over. The RN stated she verbally retrained staff on repositioning after the incident. The RN stated she and the administrator talked to ULP-B previous times regarding resident cares after staff complained to them about her.

During an interview, ULP-F stated she saw ULP-B and another ULP attempting to pick the resident up underneath his arms during a transfer from his wheelchair to his bed. ULP-F stated she told ULP-B and the other ULP to use the mechanical lift device. ULP-F stated one time she

found the resident almost falling out of his chair, stating ULP-B had her back to the resident, sitting and talking on her phone at the nurse's desk. ULP-F stated she had minimal training when she was hired. ULP-F stated her floor training lasted two days. ULP-F stated the first day she observed resident cares, and the second day she performed resident cares on her own.

In conclusion, neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, unable to interview due to cognitive status.
Family/Responsible Party interviewed: Yes. Two family members were interviewed.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Todd County Attorney
Long Prairie City Attorney
Long Prairie Police Department
Minnesota Board of Nursing
Minnesota Board of Examiners for Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

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VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 13, 2022, and February 9, 2022, the Minnesota Department of Health initiated an investigation of complaint HL38580002C/#HL38580001M and HL38580004C. At the time of the evaluation, there were 25 residents receiving services under the provisional assisted living license. The following correction orders are issued for #HL38580002C/#HL38580001M, tag identification 510, 630, 1640, 2350 and 2360. The following correction orders are issued for #HL38580004C, tag identification 620, 1710, 1720, 1760, 1940, 3000. The following correction orders are issued for both #HL38580002C/#HL38580001M and #HL38580004C, tag identification 100, 1320, 1440, 1540 and 1650.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 100 SS=I	144G.10 Subdivision 1 License required 144G.10 Subdivision 1. License required. (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:? (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with	0 100		

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0 100	Continued From page 2 dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to obtain assisted living facility with dementia care licensure and operated without a license while providing assisted living services to residents between August 1, 2021 and December 3, 2021. During the time without licensurse two of seven residents (R1, R3) reviewed experienced harm and/or injury. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's comprehensive home care provider license expired validation on July 31, 2019. Assisted Living Licensure laws and regulation went into affect on August 1, 2021, requiring any licensee with a previous housing with service location which serve dementia care residents to apply or convert to an assisted living facility with dementia care license. The licensee failed to convert or apply for assisted living facility with dementia care license by August 1, 2021 and operated without a license providing services to residents, including memory	0 100		

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0 100	Continued From page 3 care residents at during the time. Minnesota Department of Health (MDH) record, indicated on December 3, 2021, the licensee paid for the assisted living facility with dementia care license and was granted a provisional assisted living licenses with conditions due to applying late, after August 1, 2021. On January 13, 2022, MDH investigated a maltreatment complaint allegation for #HL38580002C/#HL38580001M. The incident regarding resident (R)1 occurred between August 1, 2021 to December 3, 2021, while the licensee operated without a license. At the time of the survey, the licensee was serving 25 residents. On February 9, 2022, MDH investigated a maltreatment complaint allegation for #HL38580004C/#HL38580003M. The incident regarding R3 occurred between August 1, 2021 to December 3, 2021, while the licensee operated without a license.At the time of the survey, the licensee was serving 25 residents. As a result of both survey visits, eight level 3 tags were issued related to either R1 and/or R3. TIME PERIOD OF CORRECTION: 7 days	0 100		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 4 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to COVID-19. This had the potential to affect all 25 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings Include: EYE PROTECTION The facility failed to ensure staff wore the required personal protective equipment (PPE) while in resident care areas or when performing direct resident cares. The Minnesota Department of Health (MDH) guidance titled, COVID-19 PPE and Source Control Grids, dated December 7, 2021, indicated health care workers working with residents without suspected or confirmed SARS-CoV-2 ware eye protection and facemasks in	0 510		

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0 510	Continued From page 5 communities with moderate and high community transmission levels. The Centers for Disease Control and Prevention (CDC) guidance titled, Strategies for Optimizing the Supply of Eye Protection, updated September 13, 2021, indicated healthcare personnel (HCP) working in areas of high substantial transmission should use eye protection during all resident encounters. On January 13, 2022, at 10:15 a.m., the state surveyor entered the facility. On January 13, 2022, at 10:20 a.m., unlicensed personnel (ULP)-E was observed not wearing a facemask or protective eyewear while assisting a resident in the common area of the facility. On January 13, 2022, at 10:20 a.m., ULP-F was observed not wearing a facemask or protective eyewear as she walked down the resident hall. On January 13, 2022, at 10:25 a.m., housing director (HD)-L was observed not wearing protective eyewear as she sat at the reception desk located in a residential common area of the facility. On January 13, 2022, at 10:50 a.m., ULP-F stated, they used to have protective eyewear up until two weeks ago. ULP-F stated she did not know where protective eyewear was located. The licensee's undated policy titled, COVID-19 Action Plan, indicated the licensee followed MDH recommendations for COVID-19 for assisted living facilities. DISINFECTING REUSABLE MEDICAL	0 510		

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0 510	Continued From page 6 EQUIPMENT The licensee failed to ensure the thermometer and pulse oximeter were properly disinfected after each use. MDH guidance titled, COVID-19 Action Plan for Congregate Care Settings, updated December 21, 2021, indicated shared equipment should be cleaned and disinfected after each use. Disinfectant products should be easily accessible, if possible. On January 13, 2022, at 10:15 a.m., the state surveyor entered the facility. Upon entering, the surveyor observed a rectangular table with a sign indicated staff and visitors were required to complete the COVID-19 symptom checklist. The checklist included a place for staff and visitors to check-off symptoms, log their temperatures, and blood oxygen level using a pulse oximeter. The state surveyor observed only one pen on the table and hand sanitizer to use after taking temperatures and blood oxygen levels. The table lacked a disinfectant for staff and visitors to properly disinfect the thermometer and pulse oximeter after being used. During an interview on January 22, 2022, at 11:10 a.m., the administrator (AD)-H, stated he was unaware shared equipment needed to be cleaned after each use. The licensee policy titled, Disinfecting Reusable Equipment and Environmental surfaces, dated January 2014, indicated reusable equipment and environmental surfaces would be properly disinfected after use. RESIDENT USE OF PPE IN COMMON AREAS	0 510		

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0 510	Continued From page 7 The licensee failed to ensure residents wore facemasks in common areas. The MDH guidance titled, COVID-19 PPE and Source Control Grids, dated December 7, 2021, indicated residents living in areas with high community transmission levels wore face coverings or masks, regardless of their vaccination status. On January 13, 2022, at 10:40 a.m., ULP-E was observed assisting a resident with using her walker. The resident was observed not wearing any face covering or mask while ULP-E assisted her down a narrow hallway in the facility. On January 13, 2022, at 11:30 a.m., residents were observed not wearing face coverings or masks while waiting for lunch. The residents were seated four to a table, siting less than six feet apart. On January 13. 2022, at 11:10 a.m., registered nurse (RN)-D stated all staff were trained on infection control. The licensee policy titled, COVID-19 Action Plan, updated March 25, 2020, indicated the licensee complied with MDH guidelines. TIME PERIOD TO CORRECT: Two (2) days.	0 510		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 8 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults for one of seven residents (R3) reviewed. The licensee failed to file a Minnesota Adult Abuse Reporting Center (MAARC) report after R3 was found unresponsive in the licensee's memory care unit. R3 was sent to the hospital and diagnosed with hyperglycemia and severe dehydration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's record was reviewed. R3 was admitted to the licensee on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes, and diabetic retinopathy of both eyes.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

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VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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0 620	Continued From page 9 R3's undated service plan indicated R3 received assistance with personal cares, medication management including insulin management, transfers, hourly safety checks, repositioning, and blood sugar checks three times per day. R3 walked using a four-wheeled walker and required the use of a gait belt and the assist of one staff person for all walking, and the assist of two staff persons if R3 was weak or tired. R3's registered nurse (RN) assessment dated July 30, 2021, indicated R3 received blood glucose checks five times per day per R3's primary care provider's (PCP) orders dated November 20, 2019. R3 required assistance with insulin administration and occasionally resisted taking her medications. Staff were to attempt medication administration three times before documenting R3's refusal and notifying the RN. The RN would attempt to administer R3's medications before disposing her medications. Specific instructions were given with R3's Humalog (short acting) insulin and when to notify the RN when R3's blood glucose results were below 70 mg/dL and above 300 mg/dL. R3 required Humalog insulin with each meal and Lantus (long acting) insulin in the morning and bedtime. R3's blood sugars (glucose) were monitored before each administration per R3's PCP orders. Staff were to review R3's medication administration record (MAR) for specific orders and guidelines. R3's assessment indicated R3 required frequent dosage changes or review of her blood glucose tests. R3's undated Individualized Treatment and Therapy Plan, indicated the facility changed R3's PCP blood glucose monitoring orders from five times per day to three times per day without orders from R3's PCP. R3's treatment and	0 620		

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0 620	Continued From page 10 therapy plan indicated the RN was notified whenever R3's blood glucose was below 70 mg/dL, or above 300 mg/dL R3's MAR dated August 2021, indicated R3 was prescribed the following insulin: Lantus-administer 20 Units subcutaneous (SQ) in the morning (8:30 a.m.) if blood glucose over 90 mg/dL; Humalog 100 Units per 1 milliliter (mL); 14 Units was administered after breakfast if resident ate over 75% of her breakfast. RN contacted if resident consumed less than 75% of her breakfast; Humalog, 100 Units per 1 mL. 12 Units injected SQ after lunch (12:45 p.m.), if blood glucose over 120 mg/dL, 12 Units administered SQ if resident consumed over 75% of her lunch. RN contacted if resident consumed less than 75% of lunch; lispro-7 Units SQ (6:30 p.m.) if resident consumed 2/30 grams (gm) of carbohydrates and ate 75% of her dinner. RN was notified if resident's blood glucose was under 120 mg/dL, and resident ate less than 75% of her meal. R3's MAR indicated the on-call RN was notified before staff administered R3's insulin. R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with PCP-P. Updated verbal orders transcribed by RN-J included the following: Continue Lantus 20 Units SQ in the morning (7:30 a.m.); change morning Humalog to 12 Units SQ (8:45 a.m.); continue Humalog 12 Units SQ at noon (11:45 a.m.); discontinue 6:30 p.m. insulin (Humalog 12 Units). R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal. R3's record indicated R3 refused or was not administered her insulin on the following dates: *August 1, 202, at 8:02 a.m. R3 sleeping. Blood	0 620		

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0 620	Continued From page 11 glucose-129 mg/dL. *August 7, 2021, at 7:54 a.m. Held per RN; R3 did not eat. Blood glucose-147 mg/dL. *August 8, 2021, at 12:35 p.m. Not administered. R3 eating. Blood glucose-233 mg/dL. *August 12, 2021, at 4:49 p.m. R3 refused. No reason documented. Blood glucose-136 mg/dL. *August 13, 2021, at 11:06 a.m. Held per RN. No reason documented. Blood glucose-249 mg/dL. *August 16, 2021, at 7:36 a.m. Held. R3 consumed only 25% of her meal. Blood glucose-182 mg/dL. *August 18, 2021, at 1:33 p.m. Not administered. No reason documented. Blood glucose-210 mg/dL. *August 23, 2021, at 4:51 p.m. Not administered. R3 consumed only 25% of her meal. Blood glucose-317 mg/dL. *August 24, 2021, at 8:05 a.m. R3 refused. Blood glucose-142 mg/dL. *August 25, 2021, at 11:58 a.m. Held per RN. No reason documented. Blood glucose-243 mg/dL. *September 8, 2021, at 7:42 a.m. Held per RN. R3 consumed less than 75% of meal. Blood glucose-255 mg/dL. *September 9, 2021, at 11:35 a.m. Not administered. R3 eating. Blood glucose-216 mg/dL. *September 11, 2021, at 11:46 a.m. Not administered. R3 refused to eat. Blood glucose-239 mg/dL. *September 12, 2021, at 11:44 a.m. R3 refused. No reason documented. Blood glucose-235 mg/dL. *September 14, 2021, at 10:42 a.m. Morning and afternoon insulin not administered. Blood glucose-519 mg/dL. R3's Individual Abuse Prevention Plan (IAPP) dated, September 1, 2021, indicated R3 was	0 620		

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0 620	Continued From page 12 unable to activate the emergency call system. Staff performed safety checks every 30 to 60 minutes. R3 unable to report abuse or neglect. The IAPP indicated staff were required to immediately reported any signs of abuse or neglect. R3's blood glucose checklist dated August 30, 2021, to September 14, 2021, indicated R3's blood glucose levels were above 300 mg/dL on the following days: *August 30, 2021, at 5:26 p.m.: 326 mg/dL *September 3, 2021, at 4:39 p.m.: 339 mg/dL *September 5, 2021, 11:43 a.m.: 367 mg/dL. *September 7, 2021, at 7:53 a.m.: 388 mg/dL *September 7, 2021, at 4:45 p.m.: 300 mg/dL *September 8, 2021, at 12:42 p.m.: 386 mg/dL *September 9, 2021, 6:05 p.m.: 475 mg/dL *September 10, 2021, at 7:46 a.m.: 326 mg/dL *September 10, 2021, at 12:08 p.m.: 363 mg/dL *September 12, 2021, at (unknown time): 413 mg/dL *September 13, 2021, at 12:20 p.m.: 341 mg/dL *September 14, 2021, at 10:42 a.m.: 519 mg/dL. R3's record lacked evidence R3's PCP was updated on R3's elevated blood glucose readings between August 30, 2021, and September 13, 2021, or updated after R3's insulin changes. R3's progress note dated September 9, 2021, at 6:07 p.m., written by RN-D, indicated R3's blood glucose level was 475 milligrams per deciliter (mg/dL). Insulin was administered as ordered. Staff would continue to monitor R3. R3's faxed communication note dated September 13, 2021, sent by RN-J to PCP-P, indicated RN-J requested PCP-P signed insulin orders for R3's	0 620		

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0 620	Continued From page 13 updated insulin change, dated August 27, 2021. R3's record lacked evidence RN-J updated PCP-P on R3's elevated blood glucose levels between August 27, 2021, and September 13, 2021. R3's progress note dated September 13, 2021, at 9:53 a.m., written by RN-D, indicated R3's blood glucose level was 468 mg/dL. Insulin was administered as ordered. Staff would continue to monitor R3. R3's progress note dated September 14, 2021, at 11:06 a.m., written by RN-D, indicated R3's blood glucose level was 519 mg/dL. R3's insulin was given as ordered. R3's progress note indicated RN-D placed a telephone call to R3's primary care provider's (PCP)-P regarding R3's blood glucose levels. R3's progress note dated September 14, 2021, at 1:10 p.m., written by RN-D, indicated a faxed communication was sent to R3's PCP with updated blood glucose levels. R3's progress note dated September 15, 2021, at 12:41 a.m., written by RN-D, indicated ULP-Q found R3 was not acting her normal self. ULP-Q reported R3 was dressed in her daytime clothes and was difficult to wake up. ULP-Q indicated R3's blood glucose level was 175 mg/dL. ULP-Q reported R3's blood pressure remained hypotensive after it was rechecked. ULP-Q reported to RN-D, R3 was drooling and lethargic. R3 was transported to the local hospital via emergency medical services (EMS). R3's police report dated September 15, 2021, indicated law enforcement arrived at the facility at	0 620		

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0 620	Continued From page 14 12:51 a.m. R3's police report indicated law enforcement found R3 laying on the floor in the memory care unit. R3 appeared not to be breathing. Law enforcement administered R3 oxygen via simple face mask at 10 liters per minute (LPM). ULP-Q reported at 11:00 p.m., R3 appeared, "not to be herself." ULP-Q reported R3 appeared to be slightly better after staff administered her orange juice. R3's police report indicated staff called 911 after R3 no longer responded to their commands. R3's ambulance report dated September 15, 2021, indicated the facility contacted EMS at 12:48 a.m.. EMS arrived at the facility on September 15, 2021, at 12:56 a.m. R3's ambulance report indicated EMS found R3 laying on the floor. Law enforcement was administering R3 oxygen via simple face mask at 10 liters per minute (LPM). The ambulance report indicated on September 15, 2021, at 12:00 a.m., ULP-Q administered thickened juice and gave R3 a cookie in an attempt to assist R3 to the bathroom. ULP-Q reported R3 did not eat dinner and reported feeling very tired all evening. EMS took R3's vital signs and reported all were within normal range except R3's blood glucose, which was measured at 272 mg/dL. R3's ambulance report indicated no blood glucose raising medication (glucagon) was administered to R3 while enroute to the hospital. On September 15, 2021, at 1:11 a.m., EMS left the facility and arrived at the hospital on September 15, 2021, at 1:15 a.m. R3's progress note dated September 15, 2021, at 2:24 a.m., written by ULP-Q, indicated when ULP-Q arrived to work the overnight shift she found R3 still in her street clothes sitting in the recliner in the common area of the memory care	0 620		

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0 620	Continued From page 15 unit. R3's progress note indicated R3 was last toileted at 5:00 p.m. on September 14, 2021. ULP-Q wrote R3 refused dinner, but ate a cookie. ULP-Q indicated she tried to get R3 up from the recliner but R3 did not wake up, and did not look "right." R3's progress note indicated R3 was drooling, her lower lip was drooping, and her tongue appeared swollen. R3's progress note indicated ULP-Q updated RN-D on R3's condition. RN-D told ULP-Q to administer orange juice to "wake her up a bit." ULP-Q transferred R3 in a wheelchair to R3's room with assistance from another ULP. During a brief change, ULP-Q noted R3 had an open wound on her left buttock, and was incontinent of stool and urine. ULP-Q called RN-D again who advised ULP-Q to call 911. Emergency medical technicians (EMT) arrived and transported R3 to the hospital. R3's progress note indicated ULP-Q called R3's daughter after being unable to reach R3's husband. R3's hospital record dated September 15, 2021, indicated R3 was admitted with diagnoses of altered mental status (AMS), hyponatremia, acute metabolic encephalopathy, and acute kidney injury. R3's blood glucose was recorded at 345 mg/dL upon hospital arrival. R3's record lacked evidence the facility filed a MAARC (CEP) report. On February 9, 2022, at 12:15 p.m., RN-D confirmed the facility did not file a MAARC report. On February 17, 2022, at 10:00 a.m., family member (FAM)-O, stated on September 15, 2021, at 1:00 a.m., she received a phone call from the facility stating a ULP found R3 unresponsive in a chair. FAM-O stated R3 was	0 620		

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0 620	Continued From page 16 breathing, but unresponsive when she and FAM-N arrived at the hospital. FAM-O stated she wondered why the facility waited two hours to call for help. On February 17, 2022, at 12:25 p.m., RN-D stated the facility did not file a MAARC report because she felt it did not fit the category for filing a report. RN-D stated, "I guess I felt it was more of a medical thing. I was going by what the staff told me." On February 17, 2022, at 3:30 p.m., ULP-Q stated on September 14, 2021, at 11:00 p.m., she arrived to work and found R3 still in her street clothes. ULP-Q stated R3 was incontinent of urine and stool. ULP-Q stated she was told by outgoing staff, R3 was last toileted at 5:00 p.m., hours before she arrived to work. ULP-Q stated after she and the outgoing ULP counted narcotics, she attempted to assist R3 to the bathroom, but was unable to get R3 to walk. ULP-Q stated she called RN-D who told ULP-Q to administer thickened orange juice to R3, stating, "it worked in the past." ULP-Q stated she checked R3's blood glucose and vitals, and gave the results to RN-D. ULP-Q stated she thought at the time of the incident she thought the steps she took were appropriate, stating you could always go back and say things could have been done differently. The licensee policy titled, Vulnerable Adult Reporting and Investigation, dated March 26, 2019, indicated the licensee reported any suspected abuse, neglect, or financial exploitation as defined in Minnesota Statute 626.5572. If the incident appeared to be suspected abuse, neglect, or financial exploitation, the RN would immediately make an oral report to the CEP.	0 620		

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0 620	Continued From page 17 Immediately means as soon as possible, but no longer than 24 hours from the time the RN received initial knowledge the incident occurred. If unsure maltreatment has occurred, the RN, in coordination with the home care director, would immediately investigate the incident. The RN was to file a CEP report within 24 hours following the initial incident report if they were still unclear. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 630 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to address assessed areas of potential abuse and implement specific interventions to reduce the risk of abuse for one of two residents (R1) reviewed. In addition, the licensee failed to update R1's individual abuse prevention plan (IAPP) after R1's sustained a bruise near his left eye from an unknown source. This practice resulted in a level three violation (a	0 630		

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0 630	Continued From page 18 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 R1's medical record was reviewed. R1 was admitted to the facility on April 3, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included but were not limited to Down Syndrome, traumatic brain injury (TBI), and malnutrition. R1's undated service plan, indicated R1 received assistance with personal cares, feeding, Foley catheter cares, medication management, transfers, repositioning, and hourly safety checks. R1 used a wheelchair for mobility and required a total body mechanical lift with the assistance of two staff for all transfers. R1 was non-verbal, but could make his needs known through facial expressions and body language. R1's IAPP, dated September 21, 2021, indicated R1 was vulnerable to abuse or neglect due to difficulty communicating, with needed interventions of daily safety checks. Staff were to immediately report any signs of abuse. R1 was not oriented to time and place and was a fall risk. R1's IAPP lacked specific interventions for R1's listed vulnerabilities.	0 630		

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0 630	Continued From page 19 R1's incident report dated November 19, 2021, at 4:56 p.m., written by registered nurse (RN)-D, indicated staff found reddish, purple spots (petechiae) and a small shadow bruise near R1's left eyebrow and eye. RN-D and administrator (A)-H, interviewed staff, but were unable to find out how R1's injuries occurred. RN-D indicated she was unconcerned maltreatment occurred. Staff were verbally educated on removing R1's eyeglasses during repositioning and rolling him onto his side. R1's incident report indicated on November 24, 2021, R1's injuries healed. On January 13, 2022, at 1:52 p.m., a late entry was entered by RN-D, indicating the incident date occurred on November 20, 2021, at 9:45 a.m., not on November 19, 2021. R1's progress notes dated November 20, 2021, indicated RN-D received a phone call from staff indicating they found a bruise near R1's left eye brow and eye. Staff described R1's injury as, "a few dots and a, "light shadow bruise." R1's family members (FM)-C and FM-G were notified. RN-D assessed R1's eye and described R1's injuries as having "red dots and light shadow bruising" around his outer left eye. R1's hospital record dated November 20, 2021, R1 was evaluated at a local emergency department. R1's hospital record indicated R1's injuries included bruising on his left eyebrow, eye lid, and left arm pain during movement or when touched. In addition, R1's two of his right upper teeth were broken off near his gum line. R1's hospital record indicated no acute fractures were found in his skull or body. R1 discharged back to the licensee the same day. R1's IAPP was not updated after his unexplained bruise.	0 630		

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0 630	Continued From page 20 On January 20, 2022, at 2:30 p.m., RN-D stated IAPP's were updated whenever a resident experienced clinical changes. On January 25, 2022, at 3:30 p.m., A-H stated when he was notified by staff on November 20, 2021, of R1's injuries. A-H stated when he saw R1's bruise he needed information from the nurses and staff, and check incident reports. The licensee policy titled, "Monitoring of Residents and Their Services," updated March 26, 2019, indicated during a reassessment of a resident the RN would identify any new vulnerability the resident may have or any new risk the resident may pose to other vulnerable adults and identify interventions to address these issues. Any changes in the interventions were documented in the resident record and communicated with staff providing services to the resident. TIME PERIOD TO CORRECT: Seven (7) days.	0 630		
01320 SS=I	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated	01320		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

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01320	Continued From page 21 competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed in all the required areas prior to providing assisted living services for six of six unlicensed personnel (ULP-B, ULP-E, ULP-F, ULP-I, ULP-K, ULP-M), and administrator (A)-H, with records reviewed. This had the potential to affect all 25 residents who lived in the licensee's building and negatively impacted one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings Include: On January 13, 2022, at 10:15 a.m., the state investigator entered the facility. At 11:10 a.m., the state investigator requested employee training records and supervisory visits. On January 13, 2022, at 10:40 a.m.,ULP-E was	01320		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01320	Continued From page 22 observed assisting a resident from her wheelchair to her walker using a gait belt wrapped around the resident's waist. ULP-E was observed assisting the resident walk down the hall to the bathroom. On January 18, 2022, at 9:45 a.m., an email was sent to register nurse (RN)-D and A-H, requesting again, the training records, including online, orientation, and competency training for the listed employees. On January 20, 2022, at 5:28 p.m., an email was sent to registered nurse (RN)-D, requesting the supervisory visits for the ULP. A-H A-H's hire date was February 1, 2021. A-H's employee record lacked evidence A-H received competency training on use of the transfer and mobility lift. ULP-F ULP-F's hire date was March 16, 2021. ULP-F's supervisory visit record indicated ULP-F was supervised on the following tasks, with entered supervisory dates from the RN: *Supervised: August 24, 2021. Task: Obtaining vital signs. Documented: August 24, 2021, by RN-D. *Supervised: September 17, 2021. Task: Giving resident shower. Documented: January 21, 2022, by RN-D. *Supervised: October 18, 2021. Task: Assist resident with ambulation. Documented: January 21, 2022, by RN-D. *Supervised: November 17, 2021. Task: Medication counting. Documented: January 21, 2022, by RN-D.	01320		

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01320	Continued From page 23 *Supervised: December 29, 2021. Task: Ace wrap application. Documented: January 25, 2022, by RN-J. *Supervised: January 17, 2022. Task: Donning and doffing gloves. Documented: January 21, 2022, by RN-D. In addition, ULP-F's employee record lacked evidence ULP-F received competency training on use of the transfer and mobility lift. ULP-K ULP-K's hire date was July 12, 2021. On July 1, 2021, ULP-K was registered on the Minnesota Nurse Aide Registry, certificate number #10837427. ULP-K's employee record lacked evidence ULP-K received competency training on use of the transfer and mobility lift. ULP-E ULP-E's hire date was July 19, 2021. ULP-E's supervisory visit record indicated ULP-E was supervised on the following tasks, with entered supervisory dates from the RN: *Supervised: August 27, 2021. Task: Insulin administration. Documented: January 25, 2022, by RN-J. *Supervised: August 30, 2021. Task: Handwashing. Documented: January 25, 2022, by RN-J. *Supervised: August 30, 2021. Task: Transfer using mechanical lift. Documented: January 25, 2022, by RN-J. *Supervised: August 30, 2021. Task: Two-person transfer with gait belt. Documented: January 25, 2022, by RN-J. *Supervised: August 31, 2021. Task: Eye drop	01320		

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01320	Continued From page 24 administration. Documented: January 25, 2022, by RN-J. *Supervised: September 29, 2021. Task: Glucometer use. Documented: January 21, 2022, by RN-D. *Supervised: October 29, 2021. Task: Medication administration. Documented: January 23, 2022, by RN-D. *Supervised: November 29, 2021. Task: Cleaning surfaces. Documented: January 23, 2022, by In addition, ULP-E's employee record lacked evidence ULP-E received competency training on use of the transfer and mobility lift. ULP-B ULP-B's hire date was August 7, 2021. ULP-B's supervisory visit record indicated ULP-B was supervised on the following tasks, with entered supervisory dates from the RN: *Supervised: August 18, 2021. Task: Handwashing. Documented: January 23, 2022, by RN-D. *Supervised: August 30, 2021. Task: Insulin administration. Documented: January 25, 2022, by RN-D. *Supervised: September 15, 2021. Task: Medication administration. Documented: January 25, 2022, by RN-J. *Supervised: September 29, 2021. Task: Perineal cares. Documented: January 25, 2022, by RN-J. *Supervised: October 20, 2021. Task: Resident transfers. Documented: January 23, 2022, by RN-D. *Supervised: November 17, 2021. Task: Medication administration. Documented: January 25, 2022, by RN-D. In addition, ULP-B's employee record lacked	01320		

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01320	Continued From page 25 evidence ULP-B received competency training on use of the transfer and mobility lift. ULP-I ULP-I's hire date was November 19, 2021. ULP-I's supervisory visit record indicated ULP-I was supervised on the following tasks, with entered supervisory dates from the RN: *Supervised: December 13, 2021. Task: Handwashing. Documented: January 25, 2022, by RN-J. *Supervised: December 13, 2021. Task: Pericares. Documented: January 25, 2022, by RN-J. *Supervised: December 31, 2021. Task: Medication Administration. Documented: January 25, 2022, by RN-J. *Supervised: January 20, 2022. Task: Activities and Socializing in memory care. Documented: January 20, 2022, by RN-D. *Supervised: January 24, 2022. Task: One person transfer. Documented: January 24, 2022, by RN-D. ULP-I's employee record lacked evidence ULP-I received competency training on use of the transfer and mobility lift. ULP-M ULP-M's hire date was January 17, 2022. ULP-M's employment record lacked documentation the employee completed the required training and competency testing in topics listed in 144G.61, subdivision 2. In addition, ULP-M's employee record lacked evidence ULP-M received competency training on use of the transfer and mobility lift.	01320		

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01320	Continued From page 26 R1's medical record was reviewed. R1 was admitted to the facility on April 3, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included but were not limited to Down Syndrome, traumatic brain injury (TBI), and malnutrition. R1's undated service plan, indicated R1 received assistance with personal cares, feeding, Foley catheter cares, medication management, transfers, repositioning, and hourly safety checks. R1 used a wheelchair for mobility and required a total body mechanical lift with the assistance of two staff for all transfers. R1 was non-verbal, but could make his needs known through facial expressions and body language. R1's IAPP, dated September 21, 2021, indicated R1 was vulnerable to abuse or neglect due to difficulty communicating, with needed interventions of daily safety checks. Staff were to immediately report any signs of abuse. R1 was not oriented to time and place and was a fall risk. R1's progress notes dated November 20, 2021, indicated RN-D received a phone call from staff indicating they found a bruise near R1's left eye brow and eye. Staff described R1's injury as, "a few dots and a, "light shadow bruise." R1's family members (FM)-C and FM-G were notified. RN-D assessed R1's eye and described R1's injuries as having "red dots and light shadow bruising" around his outer left eye. R1's hospital record dated November 20, 2021, R1 was evaluated at a local emergency department. R1's hospital record indicated R1's injuries included bruising on his left eyebrow, eye lid, and left arm pain during movement or when	01320		

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01320	Continued From page 27 touched. In addition, R1's two of his right upper teeth were broken off near his gum line. R1's hospital record indicated no acute fractures were found in his skull or body. R1 discharged back to the licensee the same day. During an interview on January 19, 2022, at 10:00 a.m., physical therapist (PT)-A stated the facility nurse was out the week that R1's family reported the facial bruising to her. PT-A stated the facility nurse assessed R1's injury the next week. PT-A stated the PT trained the licensee staff to use the mechanical lift in spring of 2021 when R1 began using the lift. PT-A stated there was long standing concerns the staff were not using the lift correctly. PT-A stated family reported to her the facility thought the bruising and broken teeth injury must had occured during repositioning. However, PT-A stated she did not think that injury was possible with repositioning. She stated her suspicions was from using the mechanical lift incorrectly causing the injury. PT-A stated the leg straps of the lift had to be even and in corrrect position or the resident could slide or shift in the lift during transfer. PT-A stated there was fear amongst the facility staff for doing the wrong thing, so she thought whoever knew how the injury occured were too afraid to report it. On January 13, 2022, at 10:40 a.m., ULP-F stated, "I was a little bit trained on lifts." On January 13, 2022, at 10:50 a.m., ULP-E stated not all employees used the transfer lift stating some employees physically picked up residents who required a transfer lift. On January 13, 2022, at 12:45 p.m., RN-D stated although employees were trained on the use of the transfer and mobility lift, the facility did not	01320		

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01320	Continued From page 28 have a record indicating they received competency training. On January 19, 2022, at 1:30 p.m., ULP-B stated A-H demonstrated to her how to use the mechanical lift, stating, "we watched him use it on R1." On January 24, 2022, at 10:15 a.m., ULP-F stated she received two days of training when she was hired. ULP-F stated she watched another ULP perform cares during her first day of training, stating, "on the second day I was on my own." ULP-F stated at first she felt uncomfortable performing resident cares, stating, "especially passing medications." ULP-F stated some ULP's did not understand the English written instructions for the transfer mobility lift so she translated the lift instructions from English to Spanish since she spoke and wrote fluent Spanish. ULP-F stated, "they understood better if they read it in Spanish." On January 25, 2022, at 3:30 p.m., A-H stated he realized documentation was a "huge" part of his job, stating, "we can be better at documenting everything all of the time." On February 9, 2022, at 2:00 p.m., RN-D stated she did not know why the RN's supervisory dates were documented months after supervisory visits were performed. RN-D stated, "I'll have to look into this." The licensee policy titled, Documentation of Staff Orientation and Training, dated January 2014, indicated the licensee kept employee training files with the following information: *title of the program with the identification code; *presenter qualifications (RN, not the name of the person)	01320		

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01320	Continued From page 29 *curriculum outline for the training module; *learning objectives and/or competencies; *duration of the program *methodologies used for teaching (video, reading presentation, role play) *included examples or case studies used in discussion; *method used to verify learning; (test or return demonstration with criteria for a passing score; *yearly education log of offerings (date of module, who taught it, length of time for training); *attendance list of session attendees, and if there were competency demonstrations or test with each employee's score and whether they passed; *maintained summary of training/competencies with dates for each ULP. In addition, employee's personnel files would have copies of dated certificates of training/competency for each module or competency successfully achieved. TIME PERIOD TO CORRECT: Seven (7) days.	01320		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 30 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing task within 30 days of first providing services for four of six unlicensed personnel (ULP-E, ULP-F, ULP-K, ULP-M) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 20, 2022, at 5:28 p.m., an email was sent to RN-D, requesting 30-day supervisory visits for ULP. ULP-F ULP-F's hire date was March 16, 2021. ULP-F's first documented RN supervisory visit was dated August 24, 2021, on obtaining vital signs.	01440		

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01440	Continued From page 31 ULP-F's record lacked evidence the RN conducted direct supervision of ULP-F's performing a delegated task within 30 days ULP-F first performed the delegated task for residents. ULP-K ULP-K's hire date was July 12, 2021. ULP-K's employee record did not include any RN supervisory visits. ULP-K's record lacked evidence the RN conducted direct supervision of ULP-K's performing a delegated task within 30 days ULP-K first performed the delegated task for residents. ULP-E ULP-E's hire date was July 19, 2021. ULP-E's first documented RN supervisory visit was dated August 24, 2021, on medication administration and documentation. ULP-E's record lacked evidence the RN conducted direct supervision of ULP-E's performing a delegated task within 30 days ULP-E first performed the delegated task for residents. ULP-M ULP-M's hire date was January 17, 2022. ULP-M's employee record did not include any RN supervisory visits. ULP-M's record lacked evidence the RN conducted direct supervision of ULP-M's performing a delegated task within 30 days ULP-M first performed the delegated task for residents.	01440		

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01440	Continued From page 32 On January 25, 2022, at 3:30 p.m., administrator (A)-H stated he was aware the facility could have kept better documentation records, stating, "I knew when I took this job documenting was going to be a huge part of it." On January 20, 2022, at 1:30 p.m., RN-D stated she, RN-J, and A-H conducted 30-day supervisory visits. but was unable to explain why the RN supervisory visits were documented late. The licensee policy titled, Delegation of Nursing Tasks, Treatments or Therapy Tasks, dated March 26, 2019, indicated the RN would assure training and competency records for all unlicensed staff were kept up-to-date and were easily accessible to the RN or licensed health professional (LHP) so the RN or LHP could determine which staff was competent to perform various delegated tasks. TIME PERIOD TO CORRECT: Seven (7) days	01440		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	01540		

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VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01540	Continued From page 33 meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight hours of dementia care training was completed within 80 hours of employment start date for two of six unlicensed personnel (ULP-K, ULP-M) records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: On February 9, 2022, at 10:30 a.m., the state investigator entered the facility. The facility hired an unlicensed personnel ULP-M, since the state investigator's last onsite date, January 13, 2022. ULP-K ULP-K's hire date was July 12, 2021. ULP-K's employee record lacked evidence ULP-K completed the required eight hours of dementia care, specified under Minnesota Statute 144G.64, Subd. 3.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01540	Continued From page 34 ULP-M ULP-M's hire date was January 17, 2022. ULP-M's record indicated he completed the following dementia care courses: *Dementia activities-dressing and grooming. Completed January 19, 2022. Credit hours received: 0.75. *Dementia overview-overview. Completed January 19, 2022. Credit hours received: 1.00. *Dementia problem solving anger and aggression. Completed January 19, 2022. Credit hours received: 0.50. The facility's staff schedule indicated between January 17, 2022, and March 1, 2022, ULP-M worked 8 hour shifts on the following dates, totalling 176 hours worked. January 29, 2022 January 20, 2022 February 2, 2022 February 4, 2022 February 7, 2022 February 8, 2022 February 9, 2022 February 10, 2022 February 12, 2022 February 13, 2022 February 14, 2022 February 15, 2022 February 17, 2022 February 18, 2022 February 21, 2022 February 22, 2022 February 23, 2022 February 24, 2022 February 26, 2022 February 27, 2022 February 28, 2022	01540		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

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VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01540	Continued From page 35 March 1, 2022 ULP-M's employee record lacked evidence ULP-M completed the required eight hours of dementia care, specified under Minnesota Statute 144G.64, Subd. 3. On February 16, 2022, at 3:00 p.m., registered nurse (RN)-D stated she and RN-J trained ULP. RN-D stated all ULP were trained in dementia care. The licensee policy titled, Documentation of Staff Orientation and Training, dated January 2014, indicated copies of dated certificates of training and competency were stored in the employee's files. TIME PERIOD TO CORRECT: Seven (7) days.	01540		
01640 SS=G	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all	01640		

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01640	Continued From page 36 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an unlicensed personnel (ULP)-B accurately documented and provided scheduled services for one of four residents (R1) with records reviewed. ULP-B falsely documented she performed safety checks on R1 during the time R1 was at the emergency department. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: ULP-B ULP-B's hire date was August 7, 2021. ULP-B's online orientation record dated August 2021, indicated on August 13, 2021, ULP-B completed training on documentation, observing, and reporting. ULP-B's employment record lacked	01640		

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01640	Continued From page 37 documentation the employee completed training and competency testing in topics listed in 144G.61, subdivision 2. R1 R1's medical record was reviewed. R1 was admitted to the facility on April 3, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included, but were not limited to, Down Syndrome, traumatic brain injury (TBI), and malnutrition. R1's undated service plan indicated R1 received assistance with personal cares, feeding, Foley catheter cares, medication management, transfers, repositioning, and hourly safety checks. R1 used a wheelchair for mobility and required a total body mechanical lift with the assistance of two staff for all transfers. R1 was non-verbal, but could make his needs known through facial expressions and body language. R1's IAPP, dated September 21, 2021, indicated R1 was vulnerable to abuse or neglect due to difficulty communicating, with needed interventions of daily safety checks. Staff were to immediately report any signs of abuse. R1 was not oriented to time and place and was a fall risk. R1's incident report dated November 19, 2021, at 4:56 p.m., written by registered nurse (RN)-D, indicated staff found reddish, purple spots (petechiae) and a small shadow bruise near R1's left eyebrow and eye. RN-D and administrator (A)-H, interviewed staff, but were unable to find out how R1's injuries occurred. RN-D indicated she was unconcerned maltreatment occurred. R1's incident report indicated on November 24, 2021, R1's injuries healed. On January 13, 2022,	01640		

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VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01640	Continued From page 38 at 1:52 p.m., a late entry was entered by RN-D, indicating the incident date occurred on November 20, 2021, at 9:45 a.m., not on November 19, 2021 as was indicated in R1's incident report. On November 20, 2021, at 2:19 p.m., R1 arrived at the local emergency department. R1's hospital record indicated R1's injuries included bruising on his left eyebrow, eye lid, and left arm pain during movement or when touched. In addition, R1's two of his right upper teeth were broken off near his gum line. R1's hospital record indicated no acute fractures were found in his skull or body. R1 discharged back to the licensee the same day. On November 20, 2021, at 6:19 p.m., R1 was discharged back to the facility. R1's safety check record dated November, 2021, indicated on November 20, 2021, ULP-B falsely documented she performed the following safety checks on R1: *November 20, 2021, at 3:19 p.m. *November 20, 2021, at 3:48 p.m. *November 20, 2021, at 4:46 p.m. *November 20, 2021, at 5:39 p.m. During an interview on January 20, 2022, at 3:30 p.m., ULP-E stated there were many times he witnessed ULP-B documented cares were completed when they were not performed. ULP-E stated, he asked ULP-B how she would feel if she were treated the way she treated the residents. ULP-E stated ULP-B said she would feel degraded. ULP-E stated ULP-B responded the residents had dementia and were confused so it did not matter how she treated them. ULP-E said	01640		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01640	Continued From page 39 on January 17, 2022, he had enough when he discovered multiple pills in the memory care common areas, on resident floors, and in the staff bathroom. ULP-E stated he asked ULP-B is she paid attention while she worked. ULP-E stated he told ULP-B he knew she did not document the dropped medications and never notified the RN. ULP-E stated ULP-B told him it was not in her job description to document dropped medications or notify the RN. ULP-E stated on January 17, 2022, he talked to RN-D and A-H, telling them something needed to be done immediately. ULP-E stated A-H and RN-D told ULP-E they would talk to ULP-B. During an interview on January 25, 2021, at 4:16 p.m., RN-D stated on January 17, 2022, she talked to ULP-B after ULP-E met with her and A-H. RN-D stated she knew about ULP-B's previous incidents. RN-D stated it was her, RN-J, and A-H's responsibilities to ensure ULP were competently trained. RN-D stated she wondered if the residents were getting their medications. The licensee policy titled Unlicensed Personnel Job Description, dated January 2014, indicated services must be documented accurately and consistent with licensee policies. All required paperwork must be completed in a timely and legible manner. TIME PERIOD TO CORRECT: Seven (7) days.	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 40 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included the required content for four of four residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01650	Continued From page 41 of the residents). The findings include: R1 R1's medical record was reviewed. R1 was admitted to the facility on April 3, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1's diagnoses included but were not limited to Down Syndrome, traumatic brain injury (TBI), and malnutrition. R1's undated service plan, indicated R1 received assistance with personal cares, feeding, Foley catheter cares, bowel management, medication management, transfers, repositioning, daily vitals, hourly safety checks, skin treatments, laundry, and housekeeping. R1 required a total body mechanical lift for all transfers. R1's service plan lacked a contingency plan; action to be taken if the scheduled services could not be provided; information and method to contact the facility, the names and contact information of persons R1 wished to have notified in an emergency or if there was a significant change in R1's condition, including identification of and information as to who had the authority to sign for R1 in an emergency; and the circumstances in which emergency medical services were not to be summoned. R1's service plan also lacked a signature, date, and authentication by R1's family member, including the licensee documenting agreement on the services to be provided. R2 R2's medical record was reviewed. R2's	01650		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01650	Continued From page 42 diagnoses included late onset Alzheimer's Disease and sub-acute stroke. R2's undated service plan, indicated R2 received assistance with personal cares, daily bedtime alarm checks, mobility, transfers, daily behavior monitoring for irritability and wandering, hearing aid checks, drinking, meals, medication management, escorts, daily vitals, hourly safety checks, skin treatments, and laundry. R2's service plan lacked a contingency plan; action to be taken if the scheduled services could not be provided; information and method to contact the facility, the names and contact information of persons R2 wished to have notified in an emergency or if there was a significant change in R2's condition, including identification of and information as to who had the authority to sign for R2 in an emergency; and the circumstances in which emergency medical services were not to be summoned. R2's service plan also lacked a lacked a signature, date, and authentication by R2's family member, including the licensee documenting agreement on the services to be provided. R3 R3's medical record was reviewed. R3 was admitted to the facility on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes mellitus, and diabetic retinopathy of both eyes. R3's undated service plan indicated R3 received assistance with personal cares, medication management including insulin management, transfers, exercises, hourly safety checks,	01650		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01650	Continued From page 43 behaviors, repositioning, blood sugar checks three times per day, thrombus-embolus deterrent (TED) socks, housekeeping, and laundry. R3 required assist of one staff person for all walking, and the assist of two staff persons if R3 was weak or tired. R3's service plan lacked a contingency plan; action to be taken if the scheduled services could not be provided; information and method to contact the facility, the names and contact information of persons R3 wished to have notified in an emergency or if there was a significant change in R3's condition, including identification of and information as to who had the authority to sign for R3 in an emergency; and the circumstances in which emergency medical services were not to be summoned. R3's service plan also lacked a lacked a signature, date, and authentication by R3's family member, including the licensee documenting agreement on the services to be provided. R4 R4's medical record was reviewed. R 4 was admitted to the facility on April 01, 2012, and began receiving assisted living services on August 1, 2021. R4's diagnoses included dementia and anxiety. R4's undated service plan indicated R4 received assistance with personal cares, behaviors, hourly safety checks, medication management, toileting, transfers, CMS (circulation, motion, and sensation) checks, laundry, housekeeping, an orthotics brace, and mobility escorts. R4 used a wheelchair for long distances. R4's service plan lacked a contingency plan;	01650		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 44 action to be taken if the scheduled services could not be provided; information and method to contact the facility, the names and contact information of persons R4 wished to have notified in an emergency or if there was a significant change in R4's condition, including identification of and information as to who had the authority to sign for R4 in an emergency; and the circumstances in which emergency medical services were not to be summoned. R4's service plan also lacked a lacked a signature, date, and authentication by R4's family member, including the licensee documenting agreement on the services to be provided. During an interview on January 20, 2022, at 2:30 p.m., registered nurse (RN)-D stated resident's service plans were developed off of their RN assessments. RN-D stated she and another RN completed the service plans. The licensee policy titled, "Contents of Service Plans," dated January 2014, indicated all residents would have an up-to-date service plan that identified services to be provided based on the RN assessment of each resident receiving services. Resident service plans included the following: (a) description of home care services, including nursing and medication management services, treatments, and therapy services, to be provided by the licensee; (b) frequency of each service, according to the resident's current assessment and preferences; (c) the fees for the home care services the licensee provided; (d) identification of the expected source of payment (private pay by the resident or resident's representative, insurance, and public programs); (e) identification of staff providing the services; (f) schedule and methods of monitoring reviews or	01650		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01650	Continued From page 45 reassessments of the resident; (g) frequency of supervision of staff providing services and the identification of the supervisors who provided the supervision; (h) contingency plan that included: (i) action to be taken by the licensee, the resident, or resident's representative if the scheduled services were not provided; (ii) information and method for a resident or resident's representative to contact the licensee; (iii) names and contact information of persons the resident wished to have notified in an emergency or if the resident experienced a significant adverse change in their condition, including identification of and information as to who has the authority to sign for the resident in an emergency; (iv) circumstances in which emergency medical services were not summoned pursuant to provider orders. TIME PERIOD TO CORRECT: Seven (7) days.	01650		
01710 SS=G	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment when there was a change in the resident's medications for one of four residents (R3) with records reviewed.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01710	Continued From page 46 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's medical record was reviewed. R3 was admitted to the facility on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, diabetes mellitus and diabetic retinopathy of both eyes. R3's undated service plan indicated R3 received assistance with medication management including insulin management. R3's RN assessment dated July 30, 2021, indicated R3 took diabetic medication. R3's assessment indicated R3 was prescribed Humalog (short acting) insulin with each meal and Lantus (long acting) insulin in the morning and at bedtime. R3's blood glucose levels were to be monitored before each administration (five times per day). On August 27, 2021, at 10:20 a.m., R3's primary care physician (PCP)-P, wrote a new order to continue Lantus 20 Units SQ in the morning (7:30 a.m.); change morning Humalog to 12 Units SQ (8:45 a.m.); continue Humalog 12 Units SQ at noon (11:45 a.m.); discontinue 6:30 p.m. insulin	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 47 (Humalog 12 Units) due to her having low glucoses throughout the evening and at breakfast. PCP-P indicated the plan was discussed, and facility nursing staff agreed with the plan. R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with PCP-P. R3's medication administration record (MAR) dated August and September 2021, indicated RN-J transcribed PCP-P's August 27, 2021 orders as continue Lantus 20 units in the morning (7:30 a.m.); change Humalog to 12 units at 8:45 a.m. and noon; discontinue Humalog 12 units at 6:30 p.m.. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal, although that instruction was not indicated in PCP-P's orders. R3's record lacked evidence R3 was reassessed after her change in insulin to determine effectiveness of the insulin medication change. R3's blood sugar record indicated on September 14, 2021, at 10:42 a.m. her blood sugar was 519 mg/dL. R3's progress note dated September 15, 2021, at 12:41 a.m., written by RN-D, indicated unlicensed personnel (ULP)-Q found R3 was not acting her normal self. ULP-Q reported R3 was dressed in her daytime clothes and was difficult to wake up. ULP-Q indicated R3's blood glucose level was 175 mg/dL. ULP-Q reported R3's blood pressure remained hypotensive after it was rechecked. ULP-Q reported to RN-D, R3 was drooling and lethargic. R3 was transported to the local hospital via emergency medical services (EMS).	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 48 R3's police report dated September 15, 2021, indicated law enforcement arrived at the facility at 12:51 a.m. R3's police report indicated law enforcement found R3 laying on the floor in the memory care unit. R3 appeared not to be breathing. Law enforcement administered R3 oxygen via simple face mask at 10 liters per minute. ULP-Q reported at 11:00 p.m., R3 appeared, "not to be herself." ULP-Q reported R3 appeared to be slightly better after staff administered her orange juice. R3's police report indicated staff called 911 after R3 no longer responded to their commands. R3's ambulance report dated September 15, 2021, indicated the facility contacted EMS at 12:48 a.m.. EMS arrived at the facility on September 15, 2021, at 12:56 a.m. R3's ambulance report indicated EMS found R3 laying on the floor. Law enforcement was administering R3 oxygen via simple face mask at 10 liters per minute. The ambulance report indicated on September 15, 2021, at 12:00 a.m., ULP-Q administered thickened juice and gave R3 a cookie in an attempt to assist R3 to the bathroom. ULP-Q reported R3 did not eat dinner and reported feeling very tired all evening. EMS took R3's vital signs and reported all were within normal range except R3's blood glucose, which was measured at 272 mg/dL. R3's ambulance report indicated no blood glucose raising medication (glucagon) was administered to R3 while enroute to the hospital. On September 15, 2021, at 1:11 a.m., EMS left the facility and arrived at the hospital on September 15, 2021, at 1:15 a.m. R3's progress note dated September 15, 2021, at 2:24 a.m., written by ULP-Q, indicated when	01710		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 49 ULP-Q arrived to work the overnight shift she found R3 still in her street clothes sitting in the recliner in the common area of the memory care unit. R3's progress note indicated R3 was last toileted at 5:00 p.m. on September 14, 2021. ULP-Q wrote R3 refused dinner, but ate a cookie. ULP-Q indicated she tried to get R3 up from the recliner but R3 did not wake up, and did not look "right." R3's progress note indicated R3 was drooling, her lower lip was drooping, and her tongue appeared swollen. R3's progress note indicated ULP-Q updated RN-D on R3's condition. RN-D told ULP-Q to administer orange juice to "wake her up a bit." ULP-Q transferred R3 in a wheelchair to R3's room with assistance from another ULP. During a brief change, ULP-Q noted R3 had an open wound on her left buttock, and was incontinent of stool and urine. ULP-Q called RN-D again who advised ULP-Q to call 911. Emergency medical technicians (EMT) arrived and transported R3 to the hospital. R3's progress note indicated ULP-Q called R3's daughter after being unable to reach R3's husband. R3's hospital record dated September 15, 2021, indicated R3 was admitted with diagnoses of altered mental status, hyponatremia, acute metabolic encephalopathy, and acute kidney injury. R3's blood glucose was recorded at 345 mg/dL upon hospital arrival. On January 20, 2022, at 2:30 p.m., RN-D stated she and RN-J completed resident assessments, including medication reassessments. On February 17, 2022, at 1:20 p.m., PCP-P stated the facility set their own parameters, stating she left it up to the facility. PCP-P stated she expected to be contacted by facility nursing	01710		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01710	Continued From page 50 staff whenever R3's blood glucose levels were low and high. PCP-P stated if R3 had a blood glucose level of 70 milligrams per deciliter (mg/dL), so she could adjust R3's insulin. The licensee policy titled Medication Assessment and Monitoring, updated July 1, 2021, indicated the licensee monitored and reassessed the resident's medication management services as needed when the resident presented with symptoms or other issues that were medication related. TIME PERIOD TO CORRECT: Seven (7) days.	01710		
01720 SS=G	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the resident's refusal of insulin for two of four residents (R3, R4) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01720		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01720	Continued From page 51 a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R3 R3's record was reviewed. R3 was admitted to the licensee on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes, and diabetic retinopathy of both eyes. R3 clinic After Visit Summary dated June 1, 2021, indicated R3 was to receive blood glucose checks five times per day. R3's registered nurse (RN) assessment dated July 30, 2021, indicated R3 received blood glucose checks five times per day per R3's primary care provider's (PCP)-P orders dated November 20, 2019. R3 required assistance with insulin administration and occasionally resisted taking her medications. Staff were to attempt medication administration three times before documenting R3's refusal and notifying the RN. R3's undated service plan indicated R3 received assistance with medication management services, medication administration and blood sugar checks three times a day. R3's service plan failed to be updated to include blood sugar checks of five times daily. R3's undated Individualized Treatment and Therapy Plan, indicated the facility changed R3's PCP blood glucose monitoring orders from five times per day to three times per day. R3's	01720		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01720	Continued From page 52 treatment and therapy plan indicated the RN was notified whenever R3's blood glucose was below 70 mg/dL, or above 300 mg/dL. On August 27, 2021, at 10:20 a.m., R3's PCP-P, wrote a new order to continue Lantus 20 Units SQ in the morning (7:30 a.m.); change morning Humalog to 12 Units SQ (8:45 a.m.); continue Humalog 12 Units SQ at noon (11:45 a.m.); discontinue 6:30 p.m. insulin (Humalog 12 Units) due to her having low glucoses throughout the evening and at breakfast. PCP-P indicated the plan was discussed, and facility nursing staff agreed with the plan. R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with PCP-P. R3's medication administration record (MAR) dated August and September 2021, indicated RN-J transcribed PCP-P's August 27, 2021 orders as continue Lantus 20 units in the morning (7:30 a.m.); change Humalog to 12 units at 8:45 a.m. and noon; discontinue Humalog 12 units at 6:30 p.m.. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal, although that instruction was not indicated in PCP-P's orders. R3's MAR aslo indicated to only administer Lantus insulin if blood glucose over 90 mg/dL. R3's MAR indicated the on-call RN was notified before staff administered R3's insulin. At the bottom of R3's MAR's was a legend indicating what the symbols represented on the MAR's. A circle around a unlicensed personnel (ULP)'s initials on corresponding dates indicated the resident refused or skipped her medication; "H" indicated a medication was held; * symbol indicated the reader to review a note the ULP	01720		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01720	Continued From page 53 entered. R3's MARs dated August and September 2021, indicated R3 refused her insulin on the following dates: *August 12, 2021, at 6:30 p.m. Refused Humalog. No reason documented. *August 18, 2021, at 6:30 p.m. Refused Humalog. No reason documented. *August 24, 2021, at 8:05 a.m. Refused Lantus. No reason documented. *August 24, 2021, at 8:05 a.m. Refused Humalog. No reason documented *August 26, 2021, at 12:45 p.m. Refused Humalog. No reason documented. *September 4, 2021, at 8:45 a.m. Refused Humalog. No reason documented. *September 12, 2021, at 11:44 a.m. Refused Humalog. No reason documented. R3's MAR dated August and September 2021, indicated R3 refused oral medications on the following dates: *August 3, 2021. Refused oral medications. No reason documented. *August 5, 2021. Refused oral medications. No reason documented. *August 23, 2021. Refused oral medications. No reason documented. *August 26, 2021. Refused gabapentin. No reason documented. *September 4, 2021. Refused oral medications. No reason documented. *September 5, 2021. Refused melatonin, Senna S, mirtazapine, gabapentin, Preservision AREDS. No reason documented. R3's record lacked evidence the facility discussed with R3 the consequences of refusing her insulin and documented the discussion in R3's record.	01720		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01720	Continued From page 54 R3's record lacked evidence of reattempts after a refusal or un update to R3's PCP-P for repeated insulin refusals. During an interview on February 17, 2022, at 1:20 p.m., PCP-P, stated she questioned R3's refusal to take her insulin or receive blood glucose checks. PCP-P stated R3 had been taking insulin since the 1980's. During an interview on February 17, 2022, at 2:00 p.m., family member (FM)-N, stated R3 took insulin for years. FM-N stated R3 always took her insulin when she lived at home. FM-N stated if R3 refused, you waited then retried. FM-N stated it was how you approached R3. On February 17, 2022, at 3:30 p.m., ULP-Q stated she never had problems performing cares for R3. ULP-Q stated she was taught to use redirection with R3 if she initially refused her medications or cares. ULP-Q stated R3 needed to have her insulin and get her blood glucose checked stating it was for R3's health. ULP-Q stated, if R3 refused, staff need to attempt again. ULP-Q stated she did not think that was followed by other staff who performed cares for R3. ULP-Q stated R3 was always smiling and pleasant. R4 R4's medical record was reviewed. R4 was admitted to the facility on April 1, 2012. R4's diagnoses included, but were not limited to dementia, hypertension, and anxiety. R4's undated service plan indicated R4 received assistance with medication management services.	01720		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01720	Continued From page 55 R4's MAR dated January 2022, indicated R4 was prescribed the following medications: acetaminophen, 650 mg, take two 325 mg (650 mg) tablets PO every 4 hours while awake (9:00 am); famotidine, 20 mg, one tablet PO daily (9:00 am); metoprolol succinate, 25 mg, one tablet PO daily (9:00 am); rivastigmine, 13.3 mg, 1 transdermal patch daily (9:00 am); melatonin, 3 mg, one tablet PO (8:00 pm); R4's record indicated R4 refused or was not administered her medications on the following dates: *January 1, 2022. Refused rivastigmine. No reason documented *January 2, 2022. Refused rivastigmine. No reason documented. *January 16, 2022. Refused rivastigmine. No reason documented. *January 24, 2022. Refused famotidine and acetaminophen. No reason documented. *January 24, 2022. Refused metoprolol succinate. No reason documented. R4's record lacked evidence why the medications were not administered as prescribed by R4's PCP, and lacked evidence staff attempted to readminister three times before documenting R4's refusal. On February 16, 2022, at 3:00 p.m., RN-D stated staff were not able to document a medication was administered if it was given within a certain time frame. RN-D stated she would like staff to document the reason resident's refused their medications. RN-D stated, we don't have a specific number of times for refusing. We don't want to just say do you want this and then have her meds not given."	01720		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01720	Continued From page 56 The licensee policy titled, Insulin, updated July 1, 2021, indicated insulin medications must be administered according to the prescriber's orders. TIME PERIOD TO CORRECT: Seven (7) days.	01720		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	01730		

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VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01730	Continued From page 57 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update the medication management plan for one of four residents (R3) reviewed after R3's provider changed R3's daily insulin. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's medical record was reviewed. R3 was admitted to the facility on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes mellitus, and diabetic retinopathy. R3's undated service plan indicated R3 received assistance with	01730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01730	Continued From page 58 medication management including insulin management. R3's registered nurse (RN) assessment dated July 30, 2021, indicated R3 took diabetic medication. R3's assessment indicated R3 was prescribed Humalog (short acting) insulin with each meal and Lantus (long acting) insulin in the morning and at bedtime. R3's blood glucose levels were to be monitored before each administration (five times per day). R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with her primary care physician (PCP)-P. Updated verbal orders transcribed by RN-J included the following: Continue Lantus 20 units in the morning (7:30 a.m.); change Humalog to 12 units at 8:45 a.m. and noon; discontinue Humalog 12 units at 6:30 p.m.. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal. R3's record lacked evidence R3's medication management plan was updated to reflect R3's updated insulin change. During an interview on February 7, 2022, at 1:53 p.m., RN-D stated resident records were always updated whenever there was a change to the resident's services. The licensee policy titled, "Medication Management Individualized Plan," dated July 1, 2021, indicated each resident receiving medication management services, the licensee would prepare and include in their service plans, a written statement of the medication management services that were provided to the	01730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01730	Continued From page 59 resident. The policy indicated the resident's medication management plan would be updated whenever there were changes to the resident's medications. TIME PERIOD TO CORRECT: Seven (7) days.	01730		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications administered per presciber's orders and parameters one refusal for one of four residents (R3) with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 60 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's record was reviewed. R3 was admitted to the licensee on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes, and diabetic retinopathy of both eyes. R3's undated service plan indicated R3 received assistance with medication management services. R3's individualized medication management plan, dated July 30, 2021, indicated R3 required assistance with medication administration and management. The registered nurse (RN) monitored and trained unlicensed personnel (ULP) on oral medication administration. R3 was assessed as occasionally resisted taking medications. Staff were to try again after R3's first refusal. If unsuccessful, another staff would attempt to administer her medications. After three attempts, staff documented R3's refusal and notified the RN. On August 27, 2021, at 10:20 a.m., R3's primary care physician (PCP)-P, wrote a new order to continue Lantus 20 Units SQ in the morning (7:30 a.m.); change morning Humalog to 12 Units SQ (8:45 a.m.); continue Humalog 12 Units SQ at noon (11:45 a.m.); discontinue 6:30 p.m. insulin (Humalog 12 Units) due to her having low glucoses throughout the evening and at	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 61 breakfast. PCP-P indicated the plan was discussed, and facility nursing staff agreed with the plan. R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with PCP-P. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal. R3's medication administration record (MAR) dated August and September 2021, indicated RN-J transcribed PCP-P's August 27, 2021 orders as continue Lantus 20 units in the morning (7:30 a.m.); change Humalog to 12 units at 8:45 a.m. and noon; discontinue Humalog 12 units at 6:30 p.m.. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal, although that instruction was not indicated in PCP-P's orders. R3's MAR date August and September 2021, indicated R3's insulin was withheld on the following dates and times due to eating less than 75% of her meal: *August 7, 2021, at 7:54 a.m. Humalog 14 Units withheld per RN. Blood glucose: 147 mg/dL. *August 13, 2021, at 11:06 a.m. Humalog. Held per RN. No reason documented. Calcium carbonate not administered. Documented too busy to administer by ULP-B. *August 16, 2021, at 8:30 a.m. Lantus 20 Units withheld; R3 did not eat. Blood glucose: 183 mg/dL. *August 16, 2021, at 8:45 a.m. Humalog 14 Units withheld. R3 consumed less than 25% of meal. Blood glucose: 182 mg/dL. *August 18, 2021, at 1:33 p.m. Humalog not administered. No reason documented. *August 23, 2021, at 11:57 p.m. Humalog 12	01760		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 62 Units withheld per RN. Blood glucose: 132 mg/dL. *August 23, 2021, at 6:30 p.m. Humalog 7 Units withheld. R3 consumed 25 % of meal. Blood glucose: 317 mg/dL. *August 24, 2021, at 8:05 a.m. Humalog 14 Units withheld. Blood glucose: 142 mg/dL. *August 25, 2021, at 11:58 a.m. Humalog Held per RN. No reason documented. *September 8, 2021, at 7:42 a.m. Humalog 12 Units withheld per RN-J. R3 consumed less than 75% of her meal. Blood glucose: 255 mg/dL. *September 11, 2021, at 11:46 a.m. Humalog 12 Units withheld. R3 refused to eat. Blood glucose: 239 mg/dL. *September 14, 2021. Morning and afternoon insulin not administered. No reason documented. R3's record lacked evidence why the medications were not administered as prescribed by R3's PCP. On February 16, 2022, at 3:00 p.m., RN-D stated staff were not able to document a medication was administered if it was given within a certain time frame. RN-D stated she would like staff to document the reason resident's refused their medications. RN-D stated, "we don't have a specific number of times for refusing. We don't want to just say do you want this and then have her meds not given." The licensee policy titled, Medication and Treatment-Administration and Delegation, updated July 1, 2021, indicated the RN instructed ULP in the proper methods with the respect to each resident to administer the medications or perform treatment and therapy, and the ULP has demonstrated the ability to competently follow the procedures.	01760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 63 TIME PERIOD TO CORRECT: Seven (7) days.	01760		
01940 SS=G	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01940	Continued From page 64 licensee failed to ensure blood sugars were monitored per physician orders and the physician was notified for out of range blood sugars for one of four resident's (R3) reviewed. R3 had uncontrolled blood sugars following an insulin change. R3 had an unresponsive episode with a high blood sugar and was hospitalized. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's medical record was reviewed. R3 was admitted to the facility on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes mellitus, and diabetic retinopathy of both eyes. R3 clinic After Visit Summary dated June 1, 2021, indicated R3 was to receive blood glucose checks five times per day. R3's undated Individualized Treatment and Therapy Plan, indicated the facility changed R3's PCP blood glucose monitoring orders from five times per day to three times per day. R3's treatment and therapy plan indicated the RN would be notified whenever R3's blood glucose was below 70 mg/dL, or above 300 mg/dL.	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 65 R3's undated service plan indicated R3 received assistance with medication management services, medication administration and blood sugar checks three times a day. R3's service plan failed to be updated to include blood sugar checks of five times daily. R3's record lacked documentation R3's primary care physician (PCP)-P reduced blood glucose checks to three times per day. R3's blood glucose checklist dated July 7, 2021, to August 27, 2021, indicated R3's blood glucose levels were below 70 mg/dL or above 300 mg/dL readings on the following dates: *July 7, 2021, at 4:43 p.m.: 50 mg/dL *July 26, 2021, at 4:44 p.m.: 55 mg/dL *August 1, 2021, at 4:43 p.m.: 50 mg/dL. *August 4, 2021, at 4:44 p.m.: 46 mg/dL. *August 7, 2021, at 6:45 p.m.: 42 mg/dL. *August 10, 2021, at 4:47 p.m.: 59 mg/dL. *August 17, 2021, at 4:56 p.m.: 49 mg/dL *August 13, 2021, at (unknown time): 341 mg/dL *August 19, 2021, at 4:50 p.m.: 62 mg/dL *August 23, 2021, at 4:51 p.m.: 317 mg/dL *August 24, 2021, at 12:02 p.m.: 345 mg/dL R3's record lacked documentation PCP-P had been updated regarding out of range blood sugars. On August 27, 2021, at 10:20 a.m., R3's primary care physician (PCP)-P, wrote a new order to continue Lantus 20 Units SQ in the morning (7:30 a.m.); change morning Humalog to 12 Units SQ (8:45 a.m.); continue Humalog 12 Units SQ at noon (11:45 a.m.); discontinue 6:30 p.m. insulin (Humalog 12 Units) due to her having low	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01940	Continued From page 66 glucoses throughout the evening and at breakfast. PCP-P indicated the plan was discussed, and facility nursing staff agreed with the plan. R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with PCP-P. R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal, although that instruction was not indicated in PCP-P's orders. R3's blood glucose checklist dated August 27, 2021 through September 14, 2021, indicated R3 had over blood sugar readings over 300 mg/dL on the following days: *August 30, 2021, at 5:26 p.m.: 326 mg/dL *September 3, 2021, at 4:39 p.m.: 339 mg/dL *September 5, 2021, 11:43 a.m.: 367 mg/dL. *September 7, 2021, at 7:53 a.m.: 388 mg/dL *September 7, 2021, at 4:45 p.m.: 300 mg/dL *September 8, 2021, at 12:42 p.m.: 386 mg/dL *September 9, 2021, 6:05 p.m.: 475 mg/dL *September 10, 2021, at 7:46 a.m.: 326 mg/dL *September 10, 2021, at 12:08 p.m.: 363 mg/dL *September 12, 2021, at (unknown time): 413 mg/dL *September 13, 2021, at 12:20 p.m.: 341 mg/dL *September 14, 2021, at 10:42 a.m.: 519 mg/dL R3's record lacked evidence staff performed blood glucose checks five times per day as ordered by PCP-P. A fax communication dated September 7, 2021, indicated the facility contacted PCP-P for written prescriptions for R3's insulin changes, but did not report R3's uncontrolled blood sugars following a reduction in insulin.	01940		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01940	Continued From page 67 R3 record lacked documentation of communication to PCP-P regarding R3's high blood sugars between August 27, 2021 and September 14, 2021. R3's progress note dated September 15, 2021, at 12:41 a.m., written by RN-D, indicated ULP-Q found R3 was not acting her normal self. ULP-Q reported R3 was dressed in her daytime clothes and was difficult to wake up. ULP-Q indicated R3's blood glucose level was 175 mg/dL. ULP-Q reported R3's blood pressure remained hypotensive after it was rechecked. ULP-Q reported to RN-D, R3 was drooling and lethargic. R3 was transported to the local hospital via emergency medical services (EMS). R3's police report dated September 15, 2021, indicated law enforcement arrived at the facility at 12:51 a.m. R3's police report indicated law enforcement found R3 laying on the floor in the memory care unit. R3 appeared not to be breathing. Law enforcement administered R3 oxygen via simple face mask at 10 liters per minute LPM. ULP-Q reported at 11:00 p.m., R3 appeared, "not to be herself." ULP-Q reported R3 appeared to be slightly better after staff administered her orange juice. R3's police report indicated staff called 911 after R3 no longer responded to their commands. R3's ambulance report dated September 15, 2021, indicated the facility contacted EMS at 12:48 a.m.. EMS arrived at the facility on September 15, 2021, at 12:56 a.m. R3's ambulance report indicated EMS found R3 laying on the floor. Law enforcement was administering R3 oxygen via simple face mask at 10 liters per minute (LPM). The ambulance report indicated on	01940		

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	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01940	Continued From page 68 September 15, 2021, at 12:00 a.m., ULP-Q administered thickened juice and gave R3 a cookie in an attempt to assist R3 to the bathroom. ULP-Q reported R3 did not eat dinner and reported feeling very tired all evening. EMS took R3's vital signs and reported all were within normal range except R3's blood glucose, which was measured at 272 mg/dL. R3's ambulance report indicated no blood glucose raising medication (glucagon) was administered to R3 while enroute to the hospital. On September 15, 2021, at 1:11 a.m., EMS left the facility and arrived at the hospital on September 15, 2021, at 1:15 a.m. R3's hospital record dated September 15, 2021, indicated R3 was admitted with diagnoses of altered mental status (AMS), hyponatremia, acute metabolic encephalopathy, and acute kidney injury. R3's blood glucose was recorded at 345 mg/dL upon hospital arrival. R3's progress note dated September 15, 2021, at 2:24 a.m., written by ULP-Q, indicated when ULP-Q arrived to work the overnight shift she found R3 still in her street clothes sitting in the recliner in the common area of the memory care unit. ULP-Q indicated she tried to get R3 up from the recliner but R3 did not wake up, and did not look "right." R3's progress note indicated R3 was drooling, her lower lip was drooping, and her tongue appeared swollen. ULP-Q called RN-D who told ULP-Q to administer orange juice to "wake her up a bit." During an interview on February 16, 2022, at 3:00 p.m., RN-D stated R3 received daily blood glucose checks at 7:30 a.m., 11:40 a.m., and 4:45 p.m., or whenever there were additional concerns. RN-D stated R3's out-of-range blood	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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01940	Continued From page 69 glucose levels were communicated to PCP-P either through fax or phone calls, and documented in R3's progress notes. RN-D stated R3 was receiving more frequent blood glucose checks, but stated, "her husband asked for that to be changed." During an interview on February 17, 2022, at 1:20 p.m., PCP-P stated blood glucose levels were checked before meals and bed. PCP-P stated blood glucose checks four to five times per day was a "reasonable amount, " due to R3's drastic fluctuations in her blood sugars. PCP-P stated it was a "risky move" for the facility to not perform blood glucose checks for 14 hours, between 4:45 p.m. and 7:30 a.m. PCP-P stated the facility should have notified her whenever R3's blood glucose levels were out-of-range so she could adjust R3's insulin. PCP-P stated it concerned her if the facility only notified her of R3's elevated blood glucose readings, and not the blood glucose levels 70 mg/dL and lower, or when R3 refused her insulin. PCP-P stated she questioned R3's refusal to take her insulin or receive blood glucose checks. PCP-P stated, "she's been taking insulin since the 1980's, so I am questioning the fluctuations of her glucose." An Individualized Treatment and Therapy Plan Management policy was requested but not provided. The licensee policy titled, Insulin, updated July 1, 2021, indicated insulin medications must be administered according to the prescriber's orders. TIME PERIOD TO CORRECT: Seven (7) days.	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

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02350	Continued From page 70	02350		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an unlicensed personnel (ULP)-B, treated one of four residents (R1), with courtesy, respect, and dignity during medication administration, with records reviewed. ULP-B attempted to administer R1's medications to him after she dropped his medications on the bathroom floor in front of R1's family members. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B ULP-B's personnel record was reviewed. ULP-B's hire date was August 7, 2021. ULP-B's online training transcript dated August 2021, indicated ULP-B completed 9.5 hours of online training with medication administration and treatments. ULP-B's employment record lacked documentation the employee completed training and competency testing in topics listed in 144G.61, subdivision 2.	02350		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02350	Continued From page 71 R1 R1's medical record was reviewed. R1 was admitted to the facility on April 3, 2021, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R1 was discharged from the facility on January 10, 2022. R1's diagnoses included but were not limited to Down Syndrome, traumatic brain injury (TBI), craniotomies, and malnutrition. R1 used a wheelchair for mobility and required a transfer mobility device for all transfers. R1 resided in the facility's memory care unit. R1's undated service plan, indicated R1 received medication management services. R1's medication administration record (MAR), dated November 2021, indicated R1 was prescribed he following nighttime medications: acetaminophen, 500 milligrams (mg) daily (9:00 p.m.); levetiracetam, 1,000 mg, by mouth (PO) twice daily (9:00 p.m.); melatonin 3 mg, (9:00 p.m.); memmantine, 5 mg, one table PO, twice daily, (9:00 p.m.); benzoyl peroxide 5%, apply cleanser to face once daily at bedtime; clindamycin 1%, apply lotion to face after cleansing; miconnazole 2%, apply to skin between toes on both feet twice daily; vanicream, apply to both sides of legs and feet twice daily with cares, apply to other dry areas if needed; Vicks vapor rub, apply to toenails every morning (am), and bedtime, with cares. R1's hospital record dated November 20, 2021, R1 was evaluated at a local emergency department (ED), and was discharged back to the facility on November 20, 2022, at 6:19 p.m. During an interview on January 19, 2022, at 1:30	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38580	A. BUILDING: _____ B. WING _____	C 02/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02350	Continued From page 72 p.m., ULP-B stated, she did not know who trained her when she was first hired. ULP-B stated, "they trained me to give meds, basically what you're supposed to do." ULP-B admitted she has dropped R1's medications on the floor. ULP-B stated she "flushed" R1's medications after FAM-C and FAM-G told her not to administer the dropped medications, but stated, "but either way I wasn't going to give it to him." During an interview on January 20, 2022, at 9:00 a.m., family member (FM)-C stated, after R1 returned from the ED, ULP-B went to retrieve R1's medications. FM-C stated it was taking a bit, so he went to the room [bathroom] where R1's medications were stored and saw ULP-B wearing her gloves and crawling around on her hands and knees trying to find a pill she dropped. FM-C stated ULP-B announced, "I found it!" and put the pill in the medication cup with the other medications and started to pour the medications into his hand. FM-C question ULP-B what she was doing when the medication was on the floor and ULP-B stated she could get a new pill. FM-C told ULP-B she would have to get all new medications. ULP-B responded by stating, "but I was wearing gloves." FM-C stated he then asked ULP-B if this "happened a lot" and ULP-B stated, "well, those pills are small." FM-C stated at that point he told ULP-B to remove her gloves, wash her hands, apply new gloves, and administer an entire set of new medications for R1. FM-C stated ULP-B "stomped" off, eventually returning with R1's medications which she poured into FM-C's hand. FM-C stated he talked to RN-D about the incident, stating her reply was she had spoken to staff and they should know not to do that. During an interview on January 24, 2022, at 3:30 p.m., FM-G stated they brought R1 back to the	02350		

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02350	Continued From page 73 facility after he was discharged from the ED on November 20, 2021. FM-G stated when they arrived, the lights in the memeory care unit were, "completely black," except for a few dimly lit wall sconces. FM-G stated she turned the lights on due to it being a safety hazard to have residents sitting in the dark, and R1 could nott eat his meal in the dark. FM-G stated ULP-B turned the lights off again. FM-G stated she told ULP-B to please leave the lights on. FM-G stated ULP-B was "very obstinate with me." FM-G stated she then asked ULP-B for R1's medications to have with his meal. FM-G stated ULP-B came back and plopped the medication on the table and began to leave. FM-G asked she observed his Colace and told ULP-B she was missing his other medications. FM-G stated ULP-B, "stomped" off. FM-G stated that was when FM-C found ULP-B picking up dropped pills from the bathroom floor. FM-G stated she voiced her concerns to administrator (A)-H regarding ULP-B's competency in medication administration. FM-G stated A-H stated to her, "we need to do better." The licensee policy titled, Unlicensed Personnel Job Description, updated October 27, 2014, indicated ULP dealt tactfully and compassionately with residents, their family members, and staff, and exhibited good customer service skills at all times. TIME PERIOD TO CORRECT: Seven (7) days.	02350		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 74 This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one resident reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On March 2, 2022, the Minnesota Department of Health (MDH) issued a determination that neglect and abuse occurred, and that the facility was responsible for the maltreatment, in connection with incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph	03000		

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03000	Continued From page 75 (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting maltreatment of vulnerable adults for one of seven residents (R3) reviewed. The licensee failed to file a Minnesota Adult Abuse Reporting Center (MAARC) report after R3 was found unresponsive in the licensee's memory care unit. R3 was sent to the hospital and	03000		

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03000	Continued From page 76 diagnosed with hyperglycemia and severe dehydration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's record was reviewed. R3 was admitted to the licensee on April 22, 2019, under the comprehensive home care license, and began receiving assisted living services on August 1, 2021. R3's diagnoses included dementia, insulin dependent diabetes, and diabetic retinopathy of both eyes. R3's undated service plan indicated R3 received assistance with personal cares, medication management including insulin management, transfers, hourly safety checks, repositioning, and blood sugar checks three times per day. R3 walked using a four-wheeled walker and required the use of a gait belt and the assist of one staff person for all walking, and the assist of two staff persons if R3 was weak or tired. R3's registered nurse (RN) assessment dated July 30, 2021, indicated R3 received blood glucose checks five times per day per R3's primary care provider's (PCP) orders dated November 20, 2019. R3 required assistance with insulin administration and occasionally resisted	03000		

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03000	Continued From page 77 taking her medications. Staff were to attempt medication administration three times before documenting R3's refusal and notifying the RN. The RN would attempt to administer R3's medications before disposing her medications. Specific instructions were given with R3's Humalog (short acting) insulin and when to notify the RN when R3's blood glucose results were below 70 mg/dL and above 300 mg/dL. R3 required Humalog insulin with each meal and Lantus (long acting) insulin in the morning and bedtime. R3's blood sugars (glucose) were monitored before each administration per R3's PCP orders. Staff were to review R3's medication administration record (MAR) for specific orders and guidelines. R3's assessment indicated R3 required frequent dosage changes or review of her blood glucose tests. R3's undated Individualized Treatment and Therapy Plan, indicated the facility changed R3's PCP blood glucose monitoring orders from five times per day to three times per day without orders from R3's PCP. R3's treatment and therapy plan indicated the RN was notified whenever R3's blood glucose was below 70 mg/dL, or above 300 mg/dL R3's MAR dated August 2021, indicated R3 was prescribed the following insulin: Lantus-administer 20 Units subcutaneous (SQ) in the morning (8:30 a.m.) if blood glucose over 90 mg/dL; Humalog 100 Units per 1 milliliter (mL); 14 Units was administered after breakfast if resident ate over 75% of her breakfast. RN contacted if resident consumed less than 75% of her breakfast; Humalog, 100 Units per 1 mL. 12 Units injected SQ after lunch (12:45 p.m.), if blood glucose over 120 mg/dL, 12 Units administered SQ if resident consumed over 75% of her lunch.	03000		

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03000	Continued From page 78 RN contacted if resident consumed less than 75% of lunch; lispro-7 Units SQ (6:30 p.m.) if resident consumed 2/30 grams (gm) of carbohydrates and ate 75% of her dinner. RN was notified if resident's blood glucose was under 120 mg/dL, and resident ate less than 75% of her meal. R3's MAR indicated the on-call RN was notified before staff administered R3's insulin. R3's progress note dated August 27, 2021, at 1:05 p.m., indicated R3's insulin was updated during an office visit with PCP-P. Updated verbal orders transcribed by RN-J included the following: Continue Lantus 20 Units SQ in the morning (7:30 a.m.); change morning Humalog to 12 Units SQ (8:45 a.m.); continue Humalog 12 Units SQ at noon (11:45 a.m.); discontinue 6:30 p.m. insulin (Humalog 12 Units). R3's progress note indicated R3's meal insulin was withheld if R3 consumed less than 75% of her meal. R3's record indicated R3 refused or was not administered her insulin on the following dates: *August 1, 202, at 8:02 a.m. R3 sleeping. Blood glucose-129 mg/dL. *August 7, 2021, at 7:54 a.m. Held per RN; R3 did not eat. Blood glucose-147 mg/dL. *August 8, 2021, at 12:35 p.m. Not administered. R3 eating. Blood glucose-233 mg/dL. *August 12, 2021, at 4:49 p.m. R3 refused. No reason documented. Blood glucose-136 mg/dL. *August 13, 2021, at 11:06 a.m. Held per RN. No reason documented. Blood glucose-249 mg/dL. *August 16, 2021, at 7:36 a.m. Held. R3 consumed only 25% of her meal. Blood glucose-182 mg/dL. *August 18, 2021, at 1:33 p.m. Not administered. No reason documented. Blood glucose-210 mg/dL. *August 23, 2021, at 4:51 p.m. Not administered.	03000		

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03000	Continued From page 79 R3 consumed only 25% of her meal. Blood glucose-317 mg/dL. *August 24, 2021, at 8:05 a.m. R3 refused. Blood glucose-142 mg/dL. *August 25, 2021, at 11:58 a.m. Held per RN. No reason documented. Blood glucose-243 mg/dL. *September 8, 2021, at 7:42 a.m. Held per RN. R3 consumed less than 75% of meal. Blood glucose-255 mg/dL. *September 9, 2021, at 11:35 a.m. Not administered. R3 eating. Blood glucose-216 mg/dL. *September 11, 2021, at 11:46 a.m. Not administered. R3 refused to eat. Blood glucose-239 mg/dL. *September 12, 2021, at 11:44 a.m. R3 refused. No reason documented. Blood glucose-235 mg/dL. *September 14, 2021, at 10:42 a.m. Morning and afternoon insulin not administered. Blood glucose-519 mg/dL. R3's Individual Abuse Prevention Plan (IAPP) dated, September 1, 2021, indicated R3 was unable to activate the emergency call system. Staff performed safety checks every 30 to 60 minutes. R3 unable to report abuse or neglect. The IAPP indicated staff were required to immediately reported any signs of abuse or neglect. R3's blood glucose checklist dated August 30, 2021, to September 14, 2021, indicated R3's blood glucose levels were above 300 mg/dL on the following days: *August 30, 2021, at 5:26 p.m.: 326 mg/dL *September 3, 2021, at 4:39 p.m.: 339 mg/dL *September 5, 2021, 11:43 a.m.: 367 mg/dL. *September 7, 2021, at 7:53 a.m.: 388 mg/dL	03000		

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03000	Continued From page 80 *September 7, 2021, at 4:45 p.m.: 300 mg/dL *September 8, 2021, at 12:42 p.m.: 386 mg/dL *September 9, 2021, 6:05 p.m.: 475 mg/dL *September 10, 2021, at 7:46 a.m.: 326 mg/dL *September 10, 2021, at 12:08 p.m.: 363 mg/dL *September 12, 2021, at (unknown time): 413 mg/dL *September 13, 2021, at 12:20 p.m.: 341 mg/dL *September 14, 2021, at 10:42 a.m.: 519 mg/dL. R3's record lacked evidence R3's PCP was updated on R3's elevated blood glucose readings between August 30, 2021, and September 13, 2021, or updated after R3's insulin changes. R3's progress note dated September 9, 2021, at 6:07 p.m., written by RN-D, indicated R3's blood glucose level was 475 milligrams per deciliter (mg/dL). Insulin was administered as ordered. Staff would continue to monitor R3. R3's faxed communication note dated September 13, 2021, sent by RN-J to PCP-P, indicated RN-J requested PCP-P signed insulin orders for R3's updated insulin change, dated August 27, 2021. R3's record lacked evidence RN-J updated PCP-P on R3's elevated blood glucose levels between August 27, 2021, and September 13, 2021. R3's progress note dated September 13, 2021, at 9:53 a.m., written by RN-D, indicated R3's blood glucose level was 468 mg/dL. Insulin was administered as ordered. Staff would continue to monitor R3. R3's progress note dated September 14, 2021, at 11:06 a.m., written by RN-D, indicated R3's blood glucose level was 519 mg/dL. R3's insulin was	03000		

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03000	Continued From page 81 given as ordered. R3's progress note indicated RN-D placed a telephone call to R3's primary care provider's (PCP)-P regarding R3's blood glucose levels. R3's progress note dated September 14, 2021, at 1:10 p.m., written by RN-D, indicated a faxed communication was sent to R3's PCP with updated blood glucose levels. R3's progress note dated September 15, 2021, at 12:41 a.m., written by RN-D, indicated ULP-Q found R3 was not acting her normal self. ULP-Q reported R3 was dressed in her daytime clothes and was difficult to wake up. ULP-Q indicated R3's blood glucose level was 175 mg/dL. ULP-Q reported R3's blood pressure remained hypotensive after it was rechecked. ULP-Q reported to RN-D, R3 was drooling and lethargic. R3 was transported to the local hospital via emergency medical services (EMS). R3's police report dated September 15, 2021, indicated law enforcement arrived at the facility at 12:51 a.m. R3's police report indicated law enforcement found R3 laying on the floor in the memory care unit. R3 appeared not to be breathing. Law enforcement administered R3 oxygen via simple face mask at 10 liters per minute (LPM). ULP-Q reported at 11:00 p.m., R3 appeared, "not to be herself." ULP-Q reported R3 appeared to be slightly better after staff administered her orange juice. R3's police report indicated staff called 911 after R3 no longer responded to their commands. R3's ambulance report dated September 15, 2021, indicated the facility contacted EMS at 12:48 a.m.. EMS arrived at the facility on September 15, 2021, at 12:56 a.m. R3's	03000		

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03000	Continued From page 82 ambulance report indicated EMS found R3 laying on the floor. Law enforcement was administering R3 oxygen via simple face mask at 10 liters per minute (LPM). The ambulance report indicated on September 15, 2021, at 12:00 a.m., ULP-Q administered thickened juice and gave R3 a cookie in an attempt to assist R3 to the bathroom. ULP-Q reported R3 did not eat dinner and reported feeling very tired all evening. EMS took R3's vital signs and reported all were within normal range except R3's blood glucose, which was measured at 272 mg/dL. R3's ambulance report indicated no blood glucose raising medication (glucagon) was administered to R3 while enroute to the hospital. On September 15, 2021, at 1:11 a.m., EMS left the facility and arrived at the hospital on September 15, 2021, at 1:15 a.m. R3's progress note dated September 15, 2021, at 2:24 a.m., written by ULP-Q, indicated when ULP-Q arrived to work the overnight shift she found R3 still in her street clothes sitting in the recliner in the common area of the memory care unit. R3's progress note indicated R3 was last toileted at 5:00 p.m. on September 14, 2021. ULP-Q wrote R3 refused dinner, but ate a cookie. ULP-Q indicated she tried to get R3 up from the recliner but R3 did not wake up, and did not look "right." R3's progress note indicated R3 was drooling, her lower lip was drooping, and her tongue appeared swollen. R3's progress note indicated ULP-Q updated RN-D on R3's condition. RN-D told ULP-Q to administer orange juice to "wake her up a bit." ULP-Q transferred R3 in a wheelchair to R3's room with assistance from another ULP. During a brief change, ULP-Q noted R3 had an open wound on her left buttock, and was incontinent of stool and urine. ULP-Q called RN-D again who advised ULP-Q to call	03000		

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03000	Continued From page 83 911. Emergency medical technicians (EMT) arrived and transported R3 to the hospital. R3's progress note indicated ULP-Q called R3's daughter after being unable to reach R3's husband. R3's hospital record dated September 15, 2021, indicated R3 was admitted with diagnoses of altered mental status (AMS), hyponatremia, acute metabolic encephalopathy, and acute kidney injury. R3's blood glucose was recorded at 345 mg/dL upon hospital arrival. R3's record lacked evidence the facility filed a MAARC (CEP) report. On February 9, 2022, at 12:15 p.m., RN-D confirmed the facility did not file a MAARC report. On February 17, 2022, at 10:00 a.m., family member (FAM)-O, stated on September 15, 2021, at 1:00 a.m., she received a phone call from the facility stating a ULP found R3 unresponsive in a chair. FAM-O stated R3 was breathing, but unresponsive when she and FAM-N arrived at the hospital. FAM-O stated she wondered why the facility waited two hours to call for help. On February 17, 2022, at 12:25 p.m., RN-D stated the facility did not file a MAARC report because she felt it did not fit the category for filing a report. RN-D stated, "I guess I felt it was more of a medical thing. I was going by what the staff told me." On February 17, 2022, at 3:30 p.m., ULP-Q stated on September 14, 2021, at 11:00 p.m., she arrived to work and found R3 still in her street clothes. ULP-Q stated R3 was incontinent of	03000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW OF LONG PRAIRIE IN	1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 84 urine and stool. ULP-Q stated she was told by outgoing staff, R3 was last toileted at 5:00 p.m., hours before she arrived to work. ULP-Q stated after she and the outgoing ULP counted narcotics, she attempted to assist R3 to the bathroom, but was unable to get R3 to walk. ULP-Q stated she called RN-D who told ULP-Q to administer thickened orange juice to R3, stating, "it worked in the past." ULP-Q stated she checked R3's blood glucose and vitals, and gave the results to RN-D. ULP-Q stated she thought at the time of the incident she thought the steps she took were appropriate, stating you could always go back and say things could have been done differently. The licensee policy titled, Vulnerable Adult Reporting and Investigation, dated March 26, 2019, indicated the licensee reported any suspected abuse, neglect, or financial exploitation as defined in Minnesota Statute 626.5572. If the incident appeared to be suspected abuse, neglect, or financial exploitation, the RN would immediately make an oral report to the CEP. Immediately means as soon as possible, but no longer than 24 hours from the time the RN received initial knowledge the incident occurred. If unsure maltreatment has occurred, the RN, in coordination with the home care director, would immediately investigate the incident. The RN was to file a CEP report within 24 hours following the initial incident report if they were still unclear. TIME PERIOD TO CORRECT: Seven (7) days.	03000		