STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Care and Rehab LLC	600 Fifth Street Southeast, Box 129 Barnesville, MN 56514

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to protect the resident's right to be free from mental abuse for 1 of 1 resident (R1) reviewed for abuse when staff, while providing cares, took a photo of R1 who was covered in feces and posted the photo to social media. Findings include: Nursing Assistant (NA)-A's Employee Acknowledgment dated and signed on 6/23/21, identified she had received, read, and understood and comply with the Valley Care and Rehab's Social Media policy. Any questions regarding this policy would be addressed by human resources. A violation of Social Media policy would result in disciplinary action and/or termination. Nursing assistant (NA)-A's personnel file identified the following: -On 7/19/21, director of nursing (DON) was made aware NA-A had utilized snapchat (social media) during work without regard as to who was in the background. NA-A admitted she had used her phone on the shift during the night. She verbalized understanding of phone expectations and when/where it was appropriate to use. -On 9/14/23, NA-A had posted pictures on social media of herself with diarrhea on covered pants in the hopper room (dirty utility room) with a caption what a shitty Friday and a thumbs up. She was informed even though the picture did not have personal information, the resident family could probably identify or suspect, with the style and color of the pants. She was informed this displayed unprofessional, and many companies would consider posting a picture such this to any online platform would be grounds for termination. She did not agree it was unprofessional and only wanted to know who had shown it to the facility. She was informed by the facility it was expected she stop posting things of that nature from this facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the State Operations Manual Appendix PP dated 8/8/24, identified the definition of mental abuse includes abuse that was facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans, or humiliates a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status, include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition without behaviors. He required supervision with sit to stand, chair to bed transfers, and ambulation up to 10 feet, partial/moderate assistance with upper body dressing, personal hygiene, substantial/maximal assistance with lower body dressing, roll left/right in bed, dependent upon staff for toileting hygiene, and used a walker and wheelchair for mobility. He had an indwelling urinary catheter and colostomy (a surgical procedure that creates an opening in the abdomen for feces waste to exit the body). R1's diagnoses included neurogenic (lack of bladder control due to brain, spinal cord, or nerve problems), arthritis, and depression. R1's care plan dated 12/12/24, identified he had an assisted daily living (ADL) self-care performance deficit related to supra pubic (empties the bladder through an incision in the abdomen instead of a tube in the urethra) urinary catheter and colostomy, and was dependent upon staff to manage these external devices and provide assistance with toilet hygiene. Review of nursing assistant schedule from 1/13/25 through 1/26/25, identified NA-A was scheduled to work on 1/17/25, Friday 4:00 p.m. to 9:30 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility investigation report dated 1/18/25, identified DON received a telephone call from a police department and a phone text message from a citizen in town regarding actions by one of the staff members of the facility. The picture showed a resident's right hand with liquid stool on it, a catheter bag on the floor with tubing attached to a stat lock (a cassette that held the urinary catheter tubing in place) and the resident's colostomy bag which had leaked. The caption to the photo was my 13th reason name at the top of photo identified a name of social media account and below it was NA-A's name. The post identified the staff member as NA-A. DON spoke with NA-A and she stated she had not made any snaps today and once she was informed of the photo evidence she confessed and told DON she had posted something to her private story, had taken it down, but not soon enough, when she realized it was inappropriate. She had a rough night prior to her shift and had influenced her decision making. NA-A had received verbal warnings in July 2021 and 2023 regarding cell phone use and social media. Education regarding facility policy on social media and electronic devices were reviewed with her and verbalized understanding. It was determined that despite the education, she lacked understanding of the seriousness of this incident as was at risk for repeat offenses, employment was terminated on 1/21/25. The photographs contained no identifying information to breach Health Insurance Portability and Accountability Ace of 1996 (HIPAA) (prohibiting the disclosure of protected health information). The photograph was not explicit in nature. The resident did not have any verbal/nonverbal distress to the incident. All resident needs were met, and it was not identified that NA-A acted in a willful manner. There was no physical confinement, punishment, or intimidation identified. DON and interdisciplinary team (IDT) determined the incident was poor judgment it would not be reported. Strict enforcement of facility cell phone policy will be implemented to protect residents, moving forward. During an interview on 1/24/25 at 1:00 p.m. complainant (C) stated NA-A had taken a picture of a resident who sat at edge of bed after the colostomy bag had exploded. The picture showed stool on the resident hand and leg and caption on the picture was 13 Reasons why. C stated she must have had a crappy day and most likely the reason she posted it. C stated this was an invasion of privacy and a HIPAA violation. During review on 1/26/25 of a photo taken by NA-A and posted to social media, the photo identified a person sitting on the edge of a bed, with the right lower arm positioned on a mattress and the right hand hung over the edge with dark golden mushy yellow substance (appeared to be stool) located on the thumb, pointer and middle fingers. The person's right leg was bare from the center of the upper thigh down to the upper calf. Located on the middle top part of the right thigh was a stat lock that held the urinary catheter tubing in place with tubing attached to the catheter bag that was located on the floor folded over. The person had a colostomy bag that hung down from their abdomen area to the right upper thigh area that contained the same stool substance located on the fingers. Top of colostomy bag was covered with material. The end of the colostomy bag clamp appeared to have let loose, and stool was located on the bed sheet off to the right side of the person and had run down the side of the mattress. There was a moderate amount of stool on the floor underneath the person's right leg. Written towards the bottom of the picture was my 13th reason and at the top of the picture identified 2 hours ago by NA-A's name. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/27/25 at 12:12 p.m. NA-A stated she had been terminated, was wrongful just from an incident with her cell phone. She had used her cell phone while she cared for a resident in his room. R1's colostomy bag had exploded, she had taken a picture of the feces, his hand, colostomy, the bed, floor, and part of his bare leg. She did not think family could have identified him in the picture there was not a picture of his face. She posted the picture of R1 on 1/17/25, while she was at work on a private social media site snapchat with only a handful of people on it. She removed it an hour later because she was ashamed, embarrassed, was unprofessional, and she let her emotions get the best of her. She knew what she was doing, did it anyway, and regrets it. R1 was not asked if the picture could be taken nor was, he aware it was taken, he had dementia. She said if R1 knew it had been taken and posted on social media it would have affected him negatively, he would have felt embarrassed and was an invasion of his privacy. NA-A stated this would not be a HIPPA violation because there were not any specific identifiers therefore, unable to identify him. On her private social media site there were at least 15 people and at least two of them worked with her at this facility. She stated only one resident currently had a colostomy and never thought about those that worked with her, and they could have identified him. Staff were allowed to have had their cell phones and used them while they worked at the facility with residents. She was unable recall any write ups in the past regarding issues with her use of cell phone at work and social media posts. During an interview on 1/27/25 at 3:11 p.m. family member (FM) stated R1 was a very private person, made sure his colostomy and urinary catheter bags were always covered. R1 was consciousness and did not want them exposed. If a picture was taken of anyone for that matter and posted on social media even without a face would be demeaning and humiliating. R1 did not know this happened but if he did, it would have bothered him and was an invasion of his privacy. During an interview on 1/27/25 at 3:37 p.m. DON stated 2021 NA-A had taken a picture with her cell phone along with another staff member at work and there was a resident behind her. She stated 2023 NA-A had taken a picture with her cell phone in a utility room by herself, held up resident's pants soiled with stool, and posted it to social media. Education was provided and included facility policy and expectations. DON stated on 1/18/27 she was made aware by a police officer (PO) on 1/17/25, NA-A had taken a picture of R1 and posted it onto social media for anyone on her account to see, unsure of how many but was too many. R1 was not aware of what happened, had a poor memory and was not interviewable. The facility had a cell phone policy in place since she became DON (2015), and staff were expected to leave their cell phones in the staff locker room while on the floor working with residents. DON stated NA-A made a poor choice in the moment, had taken a photo of a resident, and posted it to social media which affects privacy and dignity. The incident was not filed with SA, the resident was not identifiable in the photo. She stated NA-A was immature, knew what she did was wrong, used poor decision making that led her to take the picture. The incident was not a willful act and was not done to hurt or embarrass R1. A reasonable person would been upset about this and asked why are you taking a picture of my colostomy. The picture was not taken to complete cares or replace the appliance and was not necessary. Any normal person would have been embarrassed, humiliated, and felt it was demeaning. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/27/25 at 4:07 p.m. administrator stated on 1/18/25, he was made aware of the incident when NA-A had taken a picture of a resident and posted it on social media. The incident was not reported to the SA, did not meet the reportable guidelines of the algorithm. The person in the photo was unidentifiable. This employee had worked at other faculties and not sure where the photo was taken, location, or which employer. He was aware of two other incidents where NA-A used her cell phone at work and posted pictures to social media. He stated staff were expected to leave their cell phones in the locker room while at work and a sign was posted by the back door for years, no cell phones beyond these doors. Immediate action was taken to ensure that there was no other staff with personal devices on the floor, provider and family notified, educated staff, and terminated staff involved. The resident was not made aware of this incident per family request. Facility policy Free from Abuse and Neglect dated 11/1/22, identified the facility will ensure that each resident has the right to be free form abuse, neglect, and corporal punishment of any type by anyone. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, and mental abuse including abuse facilitated or enabled using technology. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental and verbal abuse was defined as verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Facility Social Media Policy dated 11/1/24, identified Valley Care and Rehab respects the desire of employees to use social media including but not limited to all social networking communications, electronic communications, and electronic information for personal expression. However, employees' use of social media can pose risks to the residents' confidential, proprietary and sensitive information, can harm the facility: reputation in the community, expose facility to discrimination and harassment claims, jeopardize facility compliance with business rules and laws including but not limited to the Health Insurance Portability and Accountability Act (HIPPA) and related laws and regulations protecting residents' protected health information (PHI). Electronic devices were defined as any device used for electronic communication or electronic information included: computers, laptops, tablets, digital cameras, video recorders, fax machines, copiers, scanners, telephone system, smart phones, cell phones, and pagers. Employees are absolutely prohibited from using social media in any way that would violate HIPPA or otherwise disclose or compromise residents' public health information (PHI). This includes but is not limited to the following: Do not use social media to post, upload, send or otherwise share or disclose a photo or video of any resident without prior written permission of the resident or the resident's authorized agent as required by applicable law. You must use Valley Care and Rehab's authorization form to obtain such prior written permission. This prohibition includes photos and videos where the resident is not easily identifiable (e.g., a photo of the resident's hand, a close-up photo of any part of a resident's body, or a photo of the back of a resident in the far background of the photo). It also includes photos or video where the resident is easily identifiable, whether in the photo or video itself or through a caption. Personal use of social media is never permitted on working time. Facility resident Consent to Photograph dated 1/1/25, located in the resident admission packet, identified I hereby authorize consent to the making of photographs of me while I am a resident at Valley Care Rehab. I understand that the photographs maybe made by my attending physician or an employee of the facility. I understand that such photographs maybe used for treatment purposes, including the assessment and evaluation of my wound(s). I understand that these images will be stored in a secure manner and will protect privacy and that they will be kept for the time required by law.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to immediately report no later than two hours, an allegation of abuse to the State Agency (SA) for 1 of 1 residents (R1) reviewed for abuse. Findings include: Nursing Assistant (NA)-A's Employee Acknowledgment dated and signed on 6/23/21, identified she had received, read, and understood and comply with the Valley Care and Rehab's Social Media policy. Any questions regarding this policy would be addressed by human resources. A violation of Social Media policy would result in disciplinary action and/or termination. NA-A's personnel file identified previous write-ups completed on the following dates: -On 7/19/21, director of nursing (DON) was made aware NA-A had utilized snapchat (social media) during work without regard as to who was in the background. NA-A admitted she had used her phone on the shift during the night. She verbalized understanding of phone expectations and when/where it was appropriate to use. -On 9/14/23, the writer had been made aware NA-A had posted pictures on social media of herself with diarrhea on covered pants in the hopper room (dirty utility room) with a caption what a shitty Friday and a thumbs up. She was informed even though the picture did not have personal information, the resident family could probably identify or suspect, with the style and color of the pants. She was informed this displayed unprofessional, and many companies would consider posting a picture such this to any online platform would be grounds for termination. She did not agree it was unprofessional and only wanted to know who had shown it to the writer. She was informed by writer it was expected she stop posting things of that nature from this facility. According to the State Operations Manual Appendix PP dated 8/8/24, identified the definition of mental abuse includes abuse that was facilitated or enabled through the use of technology, such as smartphones and other personal electronic devices. This would include keeping and/or distributing demeaning or humiliating photographs and recordings through social media or multimedia messaging. If a photograph or recording of a resident, or the manner that it is used, demeans or humiliates a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status. include, but is not limited to, photographs and recordings of residents that contain nudity, sexual and intimate relations, bathing, showering, using the bathroom, providing perineal care such as after an incontinence episode, agitating a resident to solicit a response, derogatory statements directed to the resident, showing a body part such as breasts or buttocks without the resident's face, labeling resident's pictures and/or providing comments in a demeaning manner, directing a resident to use inappropriate language, and showing the resident in a compromised position. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's quarterly Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition without behaviors. He required supervision with sit to stand, chair to bed transfers, and ambulation up to 10 feet, partial/moderate assistance with upper body dressing, personal hygiene, substantial/maximal assistance with lower body dressing, roll left/right in bed, dependent upon staff for toileting hygiene, and used a walker and wheelchair for mobility. He had an indwelling urinary catheter and colostomy (a surgical procedure that creates an opening in the abdomen for waste to exit the body). R1's diagnoses included neurogenic (lack of bladder control due to brain, spinal cord, or nerve problems), arthritis, and depression. R1's care plan dated 12/12/24, identified he had an assisted daily living (ADL) self-care performance deficit related to supra pubic (empties the bladder through an incision in the abdomen instead of a tube in the urethra) urinary catheter and colostomy, and was dependent upon staff to manage these external devices and provide assistance with toilet hygiene. Review of nursing assistant schedule from 1/13/25 through 1/26/25, identified NA-A was scheduled to work on 1/17/25, Friday 4:00 p.m. to 9:30 p.m. Facility investigation report dated 1/18/25, identified DON received a telephone call from Barnesville Police department and a phone text message from a citizen in Barnesville regarding actions by one of the staff members of the facility. The picture showed a resident's right hand with liquid stool on it, a catheter bag on the floor with tubing attached to a stat lock (a cassette that held the urinary catheter tubing in place) and the resident's colostomy bag which had leaked. The caption to the photo was my 13 th reason name at the top of photo identified a name of social media account and below it was NA-A's name. The PO identified the staff member as NA-A. DON spoke with NA-A and she stated she had not made any snaps today and once she was informed of the photo evidence she confessed and told DON she had posted something to her private story, had taken it down, but not soon enough, when she realized it was inappropriate. She had a rough night prior to her shift and had influenced her decision making. NA-A had received verbal warnings in July 2021 and 2023 regarding cell phone use and social media. Education regarding facility policy on social media and electronic devices were reviewed with her and verbalized understanding. It was determined that despite the education, she lacked understanding of the seriousness of this incident as was at risk for repeat offenses, employment was terminated on 1/21/25. The photographs contained no identifying information to breach Health Insurance Portability and Accountability Ace of 1996 (HIPAA) (prohibiting the disclosure of protected health information). The photograph was not explicit in nature. The resident did not have any verbal/nonverbal distress to the incident. All resident needs were met and it was not identified that NA-A acted in a willful manner. There was no physical confinement, punishment, or intimidation identified. DON and interdisciplinary team (IDT) determined the incident was poor judgment it would not be reported. Strict enforcement of facility cell phone policy will be implemented to protect residents, moving forward. During an interview on 1/24/25 at 1:00 p.m. complainant (C) stated NA-A had taken a picture of a resident who sat at edge of bed after the colostomy bag had exploded. The picture showed stool on the resident hand and leg and caption on the picture was 13 Reasons why. C stated she must have had a crappy day and most likely the reason she posted it. C stated this was an invasion of privacy and a HIPAA violation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of a photo attachment on 1/26/25 submitted with complaint identified a person sat with right lower arm positioned on a mattress and right hand hung over the edge with dark golden mushy yellow substance (appeared to be stool) located on the thumb, pointer and middle fingers. The person's right leg was bare from the center of the upper thigh down to the upper calf. Located on the middle top part of the right thigh was a stat lock that held the urinary catheter tubing in place with tubing attached to the catheter bag that was located on the floor folded over. The person had a colostomy bag that hung down from their right upper thigh area that contained the same stool substance located on the fingers. Top of colostomy bag was covered with material. The end of the colostomy bag clamp appeared to have let loose, and stool was located on the bed sheet off to the right side of the person and had ran down the side of the mattress. There was a moderate amount of stool on the floor underneath the person's right leg. Written towards the bottom of the picture was my 13th reason and at the top of the picture identified 2 hours ago by NA-A's name. During an interview on 1/27/25 at 11:07 a.m. licensed practical nurse (LPN)-A stated taking photos of residents and posting them on social media would be considered very serious HIPPA violation, and an invasion of their privacy. She had told staff in report cell phone must be placed in the staff locker room and were not allowed out on the floor while they worked. The facility had posted a yellow sign a long time ago on the door by the kitchen area that indicated: No Cell Phones Allowed Beyond this Point. During an interview on 1/27/25 at 11:17 a.m. NA-B stated staff were not allowed to have their cell phones on them while on duty and caring for residents. Residents needed to be protected and it would not be ok to take pictures and post them on social media, would be considered a HIPPA violation and most likely embarrass the resident for sure. During an interview on 1/27/25 at 12:12 p.m. NA-A stated she had been terminated, was wrongful just from an incident with her cell phone. She had used her cell phone while she cared for a resident in his room. R1's colostomy bag had exploded, she had taken a picture of the feces, his hand, colostomy, the bed, floor, and part of his bare leg. She did not think family could have identified him in the picture there was not a picture of his face. She posted the picture of R1 on 1/17/25, while she was at work on a private social media site snapchat with only a handful of people on it. She removed it an hour later because she was ashamed, embarrassed, was unprofessional, and she had let her emotions get the best of her. She knew what she was doing, did it anyway, and regrets it. R1 was not asked if the picture could be taken nor was he aware it was taken, he had dementia. She said if R1 knew it had been taken and posted on social media it would have affected him negatively, he would feel embarrassed and was an invasion of his privacy. NA-A stated this would not be a HIPPA violation because there were not any specific identifiers therefore, unable to identify him. On her private social media site there were at least 15 people and at least two of them worked with her at this facility. She stated only one resident currently had a colostomy and never though about those that worked with her, they could have identified him. Staff were allowed to have had their cell phones and used them while they worked at the facility with residents. She was unable to recall any write ups in the past regarding issues with her use of cell phone at work and social media posts. During an interview on 1/27/25 at 3:11 p.m. family member (FM) stated R1 was a very private person, made sure his colostomy and urinary catheter bags were always covered. R1 was consciousness and did not want them exposed. If a picture was taken of anyone for that matter and posted on social media even without a face would be demeaning and humiliating. R1 did not know this happened but if he did, it would have bothered him and was an invasion of his privacy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/27/25 at 3:37 p.m. DON stated 2021 NA-A had taken a picture with her cell phone along with another staff member at work and there was a resident behind her. She stated 2023 NA-A had taken a picture with her cell phone in a utility room by herself, held up resident's pants soiled with stool, and posted it to social media. Education was provided and included facility policy and expectations. DON stated on 1/18/27 she was made aware by a police officer (PO) on 1/17/25, NA-A had taken a picture of R1 and posted it onto social media for anyone on her account to see, unsure of how many but was too many. R1 was not aware of what happened, had a poor memory and was not interviewable. The facility had a cell phone policy in place since she became DON (2015) and staff were expected to leave their cell phones in the staff locker room while on the floor working with residents. DON stated NA-A made a poor choice in the moment, had taken a photo of a resident and posted it to social media which affects privacy and dignity. The incident was not filed with SA, the resident was not identifiable in the photo. She stated NA-A was immature, knew what she did was wrong, used poor decision making that led her to take the picture. The incident was not a willful act and was not done to hurt or embarrass R1. A reasonable person would been upset about this and asked why are you taking a picture of my colostomy. The picture was not taken to complete cares or replace the appliance and was not necessary. Any normal person would have been embarrassed, humiliated and felt it was demeaning. During an interview on 1/27/25 at 4:07 p.m. administrator stated on 1/18/25, he was made aware of the incident when NA-A had taken a picture of a resident and posted it on social media. The incident was not reported to the SA, did not meet the reportable guidelines of the algorithm. The person in the photo was unidentifiable. This employee had worked at other faculties and not sure where the photo was taken, location, or which employer. He was aware of two other incidents where NA-A used her cell phone at work and posted pictures to social media. He stated staff were expected to leave their cell phones in the locker room while at work and a sign was posted by the back door for years, no cell phones beyond these doors. Immediate action was taken to ensure that there was no other staff with personal devices on the floor, provider and family notified, educated staff, and terminated staff involved. The resident was not made aware of this incident per family request. Facility Combined Federal and State [NAME] of Rights last revised 2/1/17, identified each resident must be treated with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his/her quality of life. The resident has the right to be free from abuse, neglect and misappropriation of resident property, and exploitation of this subject. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Facility policy Free from Abuse and Neglect dated 11/1/22, identified the facility will ensure that each resident has the right to be free form abuse, neglect, and corporal punishment of any type by anyone. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, and mental abuse including abuse facilitated or enabled using technology. Willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mental and verbal abuse was defined as verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Facility policy titled Reporting of Reasonable Suspicion of a Crime/Reporting of Alleged Violations dated 2/14/24, identified: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Care and Rehab LLC	600 Fifth Street Southeast, Box 129 Barnesville, MN 56514

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-What should be reported: all alleged violation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. -Who is required to report: the facility. -To whom: Facility administrator, Office of Health Facility Complaints (OHFC), Clay County Social Services, Law Enforcement, Attending Physician, and Resident's Representative. -When: All alleged violations. Immediately, but not later than 2 hours. If alleged violation involves abuse or results in serious bodily injury. Facility Social Media Policy dated 11/1/24, identified Valley Care and Rehab respects the desire of employees to use social media including but not limited to all social networking communications, electronic communications, and electronic information for personal expression. However, employees' use of social media can pose risks to the residents' confidential, proprietary and sensitive information, can harm the facility: reputation in the community, expose facility to discrimination and harassment claims, jeopardize facility compliance with business rules and laws including but not limited to the Health Insurance Portability and Accountability Act (HIPPA) and related laws and regulations protecting residents' protected health information (PHI). Electronic devices were defined as any device used for electronic communication or electronic information included: computers, laptops, tablets, digital cameras, video recorders, fax machines, copiers, scanners, telephone system, smart phones, cell phones, and pagers. Employees are absolutely prohibited from using social media in any way that would violate HIPPA or otherwise disclose or compromise residents' public health information (PHI). This includes but is not limited to the following: Do not use social media to post, upload, send or otherwise share or disclose a photo or video of any resident without prior written permission of the resident or the resident's authorized agent as required by applicable law. You must use Valley Care and Rehab's authorization form to obtain such prior written permission. This prohibition includes photos and videos where the resident is not easily identifiable (e.g., a photo of the resident's hand, a close up photo of any part of a resident's body, or a photo of the back of a resident in the far background of the photo). It also includes photos or video where the resident is easily identifiable, whether in the photo or video itself or through a caption. Personal use of social media is never permitted on working time.