STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. Building B. Wing	06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Manor Hcc	200 East Ninth Avenue Lamberton, MN 56152

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 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** 39998 Based on interview and document review the facility failed to immediately report an allegation of abuse to the administrator and State Agency (SA) for 1 of 1 resident (R1) reviewed for allegations of abuse. Findings include: A Nursing Home Incident Report submitted to the State Agency on 6/18/24 at 6:12 p.m., indicated R1 reported an allegation of abuse to licensed practical nurse (LPN)-A on 6/17/24 at 2130 (9:30 p.m.). R1's Admission Minimum Data Set (MDS) dated [DATE], indicated R1 had intact cognition and no noted behaviors. R1 required staff supervision with transferring, dressing, and walking, but was independent with bed mobility. R1's Progress Note subtitled Behavior Charting dated 6/17/24 at 20:38 (10:38 p.m.), indicated R1 reported that the night prior (6/16/24), a large lady turned mean and grabbed her neck and pulled her very hard which caused her neck to hurt. R1 indicated she was afraid the woman would come back to hurt her again. R1 gave a description of the woman to the LPN-A. The progress note indicated LPN-A notified the director of nursing (DON) of the allegation with in one hour of the allegation. During an interview on 6/24/24 at 11:20 a.m., R1 stated one night a lady must have been having a bad day because she came into her room during the night and grabbed her, hurt her neck, and just left the room. R1 further stated she told staff in case it happened to someone else too. During an interview on 6/24/24 at 12:55 p.m., the director of nursing (DON) indicated LPN-A notified her of the allegation on 6/17/24 at approximately 10:30 p.m. but sounded like a hallucination. Upon arrival to the facility on [DATE], the DON indicated she read the communication book and the incident sounded more serious than she thought and informed the administrator at approximately 8:30 a.m.-9 a.m. that same morning. Further she indicated the interdisciplinary team (IDT) discussed the incident at the morning meeting and decided to report [to the SA]. The DON stated she was aware of the facility policy on reporting but thought the facility had 24 hours to report if there was no serious injury. (continued on next page)

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

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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 an interview on 6/24/24 at 1:00 p.m., LPN-A indicated on 6/17/24 at approximately 9:15 p.m., R1 was scared to go to sleep because during the night of 6/16/24 a woman was very harsh and pulled her neck. Indicated she notified the DON of the allegation at approximately 10:15 p.m. but the DON did not think it was reportable and directed to chart it [allegation] in the medical record. LPN-A stated she was concerned about the allegation enough to call the DON but they [nurses] do not report to the SA as they are directed that only the DON or administrator are to report [to the SA]. During an interview on 6/24/24 at 2:35 p.m., the administrator indicated the DON notified her of the allegation on 6/18/24 at approximately 9 a.m. and the IDT team reviewed the notes and decided it was reportable [to the SA]. The administrator further confirmed it was not reported until 6:12 p.m. on 6/18/24 and was not within the required immediate, no later than two-hour time frame per regulation. The facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation -Reporting and Investigating last reviewed 3/22/2023 indicated if resident abuse is suspected, the suspicion must be reported immediately to the administrator, director of nursing, and to other officials according to state law. The policy defines immediately as: within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.