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	08/27/2024

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview and record review the facility failed to comprehensively assess and provide an adequate plan for supervision and appropriate interventions to protect, respect and promote rights of the resident to meet individual needs, for 1 of 3 residents (R1) reviewed for elopement. Additionally, the facility failed to ensure 1 of 1 (R1) resident care plans were revised and staff were aware of interventions to maintain resident safety. Findings include: R1's admission Minimum Data Set, dated dated dated [DATE], identified intact cognition with no behaviors. R1 was independent with toileting and oral hygiene, eating, transfers, and ambulation. R1 required supervision with shower/bath, upper and lower dressing, and personal hygiene. R1 was continent of bowel and bladder. R1's diagnoses included: coronary artery disease (CAD), atrial fibrillation (AFIB), benign prostatic hyperplasia (BPH) (enlarged prostate causes obstructive urinary flow), and obstructive uropathy. R1 required no wander guard or alarms. R1's Care Area Assessment (CAA) dated [DATE], identified cognitive skills required for daily decision making and possible underlying problems that may have affected R1's cognitive function were identified as changing cognitive status, poor memory, mood decline, vision problems, and depression. R1's care plan last updated on [DATE], identified high risk for elopement or wandering. Goal: safety would be maintained through the review date. Staff were directed to assess elopement status quarterly and as needed, identify pattern of wandering (purposeful, aimless, or escapist), looking for something, or need for more exercise, and intervene as appropriate. R1's wander alert device was applied to left wrist on [DATE], expired 90 days, and added to EMAR for changing device. R1's Kardex dated [DATE], identified assess elopement status quarterly and as needed. R1 required prompt responses to all requested for assistance and wander alert devised applied to left wrist [DATE], expired 90 days, cue added to EMAR for changing device. R1's care plan and Kardex lacked staff interventions to ensure adequate supervision was provided. R1's care plan last updated on [DATE], identified R1 was an elopement risk and required supervision while outdoors due to elopement risk. (continued on next page)

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
	245378	A. Building B. Wing	08/27/2024

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Elopement assessment dated [DATE], identified R1 was ambulatory and had diagnoses of OBS (organic brain syndrome), dementia, psychosis, Alzheimer's, or other psychiatric diagnosis. R1 was identified as a low risk for elopement. Interventions selected: frequent monitoring, staff made aware of elopement risk, personalization of room (pictures, familiar items). R1's Elopement assessment dated [DATE], identified R1 had a history of elopement or an attempted elopement and remained at risk. Clinical suggestions identified: apply personal safety alarm device, notify staff of elopement risk, and monitor location frequency. R1's Brief Interview for Mental Status (BIMS) evaluation dated [DATE], identified cognition remained intact but had slightly decreased from a score of 15 to a 12 (range 13 to 15 cognitively intact). R1's primary provider/Doctor of Osteopathic Medicine (DO) (focus on holistic health and prevention) visit dated [DATE], identified cognitive decline/change in behavior. Single episode of elopement/wandering and unsure why he left. R1 does not have a diagnosis of dementia but had demonstrated some cognitive decline. Plan: blood work ordered CBC (complete metabolic panel), CBC (complete blood count), TSH (thyroid stimulating hormone) for evaluation of organic causes, had no genitourinary symptoms, held off on UA (urinalysis), and Neuropsychiatric testing for further evaluation of dementia. R1's Social Service Resident Vulnerability and Susceptibility to Abuse completed on [DATE], identified cognitive impairment, easily exploited by others, and sensory impairment. R1's Psychosocial Quarterly -V7 completed on [DATE], identified R1 declined mental health services and felt they were not needed. Family discussed possible need. R1's had someone who assisted with financial and healthcare decisions. R1 was able to make some decisions on his own. R1's cognition was identified as declined and Neuropsychiatric appointment recommended. Summary: no concerns with R1's BIMS score however believed with recent incident, and inability to recollect, a Neuropsychiatric visit may/should be recommended. R1's family in room indicated they wished to discuss this further. R1 was unable to recall recent wander incident and denied why he left. Writer believed although PHQ (patient health questionnaire) (a multipurpose instrument used for screening, diagnosing, monitoring, and measuring severity of depression) scores were good, mental health services for even short term would be beneficial. R1's progress notes on [DATE], identified: -4:41 p.m. R1 eloped from the facility today was seen leaving on camera from front entrance at 8:22 a.m. facility was searched, resident not found, local law enforcement called to assist. R1's daughter arrived shortly after the elopement. R1 had brought his jacket, a hat, and gloves. He stated upon return he had planned to stay overnight. Officers located him and brought him back to facility to be evaluated. R1 was found to be unharmed, wander guard was put in place for safety and staff initiated every 15-minute checks for the first 24 hours of his return. Tools and scissors were removed from resident room for safety. -at 11:14 p.m. R1 returned from emergency room this afternoon and a wander guard was placed on left wrist. Education was given to R1, his wife (F-A) (also resident at the facility), and daughter (F-B) regarding wander guard. They verbalized their understanding of the device and reason for use. (continued on next page)

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	08/27/2024

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation/interview on [DATE] at 2:57 p.m., R1 and F-A (also resident) sat in recliners in bedroom together with the door closed. R1 stated he wandered away from the facility, but not sure why. R1 indicated he saw a big tree, felt tired, heart ticked fast, and thought it would be a good place to rest. R1 stated the tree was located by some water but he was unsure if was a river, lake, or pond, adding his memory had not been good for three to five years now and he knew everyone thought he was crazy. R1 also stated he was aware he should not have left but he grabbed a cap, jacket, two cans of root beer, and planned to stay over night, so that was what he did. Adding, he sat by the tree, saw the water and that is where he would have gone in the morning to get out of here but they caught me be before that happened. R1 indicated he thought he was gone one and half days. During an observation/interview on [DATE] at 9:50 a.m., R1 and F-A sat in recliners in bedroom together with door closed. R1's F-A stated was too hot to go outside and sit so they had chosen to stay in their room together. During an interview on [DATE] at 1:45 p.m., nursing assistant (NA)-A stated R1 and F-A had argued the morning of [DATE], F-A later informed her she could not find R1 after breakfast, thought he just wanted time by himself. NA-A stated R1 had dementia, but F-A had always been the leader and directed him. NA-A notified charge nurse, search of premises (inside and outside) was completed, and police department notified. NA-A stated R1 was found and taken to the emergency department (ED). NA-A stated the next day R1 had on a wander guard and was not allowed to be outside by himself and required supervision by either F-A or staff. NA-A stated they usually looked in resident's Kardex or care plan in the electronic medical record if unsure how to care for them. During an interview on [DATE] at 2:07 p.m., NA-B stated R1 had dementia, poor memory, required cues, and F-A provided reminders. NA-B started mostly R1's long term memory seemed to be affected and wore a wander guard. NA-B stated R1 and his wife (F-A) were always together and very unusual for him to leave the building alone that day. Since R1's elopement, NA-B stated staff were directed to entered the door code so that R1 and F-A could go outside together. NA-A indicated R1 was not allowed to go out my himself anymore and must have either F-A, his family, or staff with him. During an interview on [DATE] at 3:35 p.m., registered nurse (RN)-A stated it was very unusual for R1 to leave building without his F-A and was now a high risk for wandering or elopement. RN-A verified she had applied the wander guard to R1's wrist once he returned from ED on [DATE]. RN-A stated when R1 asked if he could go outside she would have to explained to him, F-A and F-B that staff will need to enter the code on the door so he can go outside with either F-A, staff or other family. RN-A indicated R1 required supervision when outside and should still be supervised by staff from inside the building. RN-A stated she hoped staff were informed and aware of that; she then checked the point click care (PCC) communication board and nothing had been placed on there and explained she felt too many little things were being missed. RN-A indicated she had informed R1's wife (F-A) if he started to get up and walked away, she needed to come back inside the building and ask staff for assistance. (continued on next page)

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	08/27/2024

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:00 a.m., F-A stated R1 had talked about walking in the corn fields months ago to get lost. F-A verified she felt awful, laid awake at night with thoughts of if she would not have drank an extra cup of coffee that morning, she could have prevented all of this by going back to the room with him, and possibly stopped him from leaving. F-A stated she was ok with being alone outside with him, knew what to do when he started to walk away or refused to come back in, then got tears in her eyes and paused for a moment. F-A indicated she was informed by staff to ring doorbell outside when he started to walk away. F-A then stated she just hoped staff answered the doorbell right away because R1 moved rather fast at times. F-A also indicated R1's memory had gotten worse and she never told staff, but she had tried helping him as much as she could. During an interview on [DATE] at 10:30 a.m., NA-C indicated R1 had told her he felt more forgetful lately and was frustrated by that. NA-C stated R1 usually stayed close to F-A so his elopement was very unexpected. NA-C stated she was unsure if R1 had a wander guard on, but he had been outside with F-A many times since the elopement incident. NA-C stated residents on the patio outside were observed by staff from inside the building but R1 was allowed to go out with F-A. NA-C stated R1's interventions had not changed since incident. NA-C stated they had checked the plan of care weekly which identified how to care for each resident. NA-C stated residents were required to let staff know when they wanted to go outside, that was it. During an interview on [DATE] at 10:45 a.m., licensed practical nurse (LPN)-A stated R1 staff relied on shift report and resident Kardex to identify interventions. LPN-A verified R1's care plan identified a wander guard was in placed, but did not detail any other plans. LPN-A stated R1 required supervision outside from either F-A, family or staff through the window or if staff went outside with him. LPN-A stated they were not able to rely on shift report due to turn over. LPN-A also indicated concern related to staffing plan to watch R1 from inside as it was unlikely someone was always located at the front door or could respond to the doorbell quickly. LPN-A stated R1's cognition was not intact and was unable to decide about psych evaluations. LPN-A indicated it had appeared more difficult for F-A to intervene with him, as he did not always respond well to her, or she got upset with him and he was able to walk a lot a lot faster than her so if he left the property, by the time she located help, he could already be pretty far away. LPN-A stated F-B had mentioned this last week also adding the facility courtyard was a contained area, not being used by residents, and would be more appropriate area for R1 and his wife (F-A) to sit outside in. During an interview on [DATE] at 11:30 a.m., social worker (SW) stated she visited with R1 and family last weekend and recommended a neuro/psych consult after R1 eloped. SW stated R1 was confused as to why he left the facility alone and the family was considering mental health services. SW indicated R1 must be supervised to go outside, and confirmed F-A's supervision would not be enough. SW indicated if R1 walked off when outside and F-A had to go inside the building to find help, by that time he could have been half way across the road and possibly hit by a car. SW stated R1 moved a lot faster than F-A. SW stated that if she looked at this from the outside in, it did not seem to be the most appropriate action or plan. SW also stated she did not think F-A could bare all of that responsibility, being vulnerable herself. SW stated R1's cognition had declined relativity rapidly and his recollection was worse than when admitted . SW stated the BIMS was not a true assessment of cognitive abilities and a neuro/psych evaluation was recommended. SW verified R1's family wanted time to discuss among themselves if R1 would have benefited from mental health services. SW stated any resident with a wander guard should be supervised especially outside and included in their interventions on the care plan to be safe. SW verified the facility courtyard (contained outside area) was not used due to side walks where unleveled and deemed a safety risk. (continued on next page)

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	08/27/2024

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:25 p.m., assistant director of nursing (ADON) stated R1's family just agreed to a neuro/psych evaluation, which was ordered, and needed to get scheduled. ADON indicated SW met with R1 on Sunday and was able to answer orientation questions but unable to track past experiences. ADON stated R1 had long and short-term memory loss, BIMS was not the most accurate assessment of R1's cognition, and seemed to fluctuate, possibly some sundown (group of symptoms people with dementia experience afternoon and early evening such as confusion, trouble sleeping, anxiety, wandering, and hallucinations) may have occurred also. ADON indicted R1's incident was pretty unexpected, with no past occurrences of leaving the facility grounds and never walked without F-A. ADON indicated after the elopement, a wander guard was applied and every 15-minute checks for first 24 hours was completed. ADON stated R1 was not declared a high risk for elopement. ADON stated R1 was required to have supervision of staff when outside and his wife does not count as a person that could have supervised him because she was a resident of the facility herself. ADON verified a resident can not be allowed to supervise another resident, staff were not trained to do this. ADON stated F-A was not capable to have supervised R1 outside, had occasional forgetfulness, and unable to chase after him with a walker due to her high risk for falls. ADON indicated R1's level of supervision required by staff should have been listed on the care plan under interventions, thought about that this morning, and added to the R1's care plan today. ADON stated R1's supervision level required him to be where staff were able to visualize him and not assumed the staff just knew about this. During an interview on [DATE] at 2:01 p.m., director of nursing (DON) stated R1 was allowed to go alone outside with F-A, adding F-A supervises him in her own way as she has watched over him for over [AGE] years. DON went on to state that R1 was not officially supervised by F-A because he was his own person and she was aware of him being outside with her. DON stated F-A was expected to alert staff when he had decided to stay outside without her, because he could wander off down the road, and that would be a safety issue for sure. DON indicated staff were aware they were outside, watched them from inside through the window, relayed that to other staff if they had to step away. DON indicated F-A took on the supervisory roll herself, was not assigned to her, and an assessment had not completed to be in charge of R1. DON stated R1 and F-A were both equally here, required to be taken care by staff, as a couple required time to be together, and did not want her to be stressed out. DON stated staff were expected to have reviewed resident's care plan and/or Kardex, 24-hour report book, and receive shift change report during their shift. DON indicated R1's care plan should have included special supervision interventions so that all staff were made aware for his safety. Facility policy Care Planning - Interdisciplinary Team last reviewed [DATE], identified the facility's care planning/interdisciplinary team was responsible for development and revisions of an individualized comprehensive care plan for each resident. Facility policy Care Plans, Comprehensive Person-Centered last reviewed [DATE], identified a comprehensive, person-centered care plan includes measurable objectives and timetables to have met the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The care planning process would incorporate interventions that were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. (continued on next page)

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	08/27/2024

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Safety and Supervision of Residents last reviewed [DATE], facility strives to provide an environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents were the facility-wide priorities. The care team should have targeted interventions to reduce risks related to hazards in the environment, which included adequate supervision and assistive devices. Specific interventions are to be communicated to all relevant staff, training provided, assigned responsibility to have interventions carried out, ensure interventions were implemented, and evaluated for effectiveness.