Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

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	04/20/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to develop a comprehensive person-centered Elopement care plan that included interventions to mitigate the risk of elopement for 1 of 1 resident (R1) reviewed for accidents. Findings include:R1's face sheet dated 4/15/26, identified diagnoses of unspecified dementia without behavioral disturbance and depression.R1's Quarterly Minimum Date Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, had delusions/hallucinations, no other behaviors, no rejection of care, no wandering, did not use a walker or wheelchair, was independent with transfer and ambulation, had two or more falls since admission with no injury, and used a wander/elopement alarm daily. R1's elopement evaluation dated 3/26/26, identified R1 was at risk for elopement due to wandering behaviors that were likely to affect the safety or wellbeing of others. R1 had a personal safety device applied.During an interview on 4/15/26 at 4:25 p.m., director of nursing (DON) stated R1 had an elopement evaluation completed on 3/26/26 due to R1 making exit seeking comments and was determined to be at risk for elopement and had a wanderguard (name brand for a personal safety device) placed as an intervention. DON explained R1 had not used a wanderguard prior to that date.Review of R1's care plan 3/26/26 through 4/13/26, did not identify an elopement focus care plan had been initiated with interventions to prevent R1 from leaving the facility unsupervised.R1's elopement incident report dated 4/13/26, identified R1 had been brought a sandwich at 4:55 a.m., when brought R1 pudding to her room at 5:03 a.m., R1 was not in her room. Staff searched the facility and grounds, called management, and found R1 at 5:28 a.m. R1 refused to return to the facility.R1's record identified R1's care plan for elopement was not developed and initiated until 4/15/26 which included R1 was at risk for wandering/elopement. Goal that R1 will not leave facility unattended. Interventions dated 4/15/26 as follows:-Clearly identify resident's room and bathroom.-Identify if there are triggers for wandering/eloping. R1 is suspected to have Lewy Body type dementia; provide R1 with medications as ordered.-Identify if there is a certain time of day wandering/elopement attempts to occur.-Identify if there is a certain time of day wandering/elopement attempts occur.-Identify wandering/elopement de-escalation behaviors.-Provide care in calm and reassuring manner.-Provide clear and simple instruction. During an interview on 4/15/26 at 12:58 p.m., nursing assistant (NA)-F stated R1 had a wanderguard put on her a few weeks prior to her elopement and was told she had removed her own bracelet on 3/29/26 and refused to have another bracelet applied. NA-F stated she was not aware if R's care plan had any increased supervision since she had cut off her bracelet nor any other interventions in place to prevent her from eloping. NA-F explained R1 would always wander in the hallways through the day but was unsure if she had attempted to leave the facility prior to leaving on 4/13/26, however, R1 would make comments that she wanted to leave the facility at times. During an interview on 4/16/26 at 4:42 p.m., director of nursing (DON) stated R1 should have had a wandering/elopement care plan initiated on 3/26/26 when the elopement assessment had been completed to inform staff of needed interventions to mitigate the risk of R1 eloping, however, R1 elopement care plan was not initiated until 4/15/25 after R1 had eloped on 4/13/26. Review of the facility's Care Plans, Comprehensive (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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Person-Centered Policy undated, identified a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will: -Include measurable objectives and timeframes. -Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. - Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. -Describe any specialized services to be provided as a result of PASARR recommendations. -Include the resident's stated goals upon admission and desired outcomes. -Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire. -Incorporate identified problem areas. -Incorporate risk factors associated with identified problems. -Build on the residents' strengths. -Reflect the resident's expressed wishes regarding care and treatment goals. -Reflect treatment goals, timetables, and objectives in measurable outcomes. -Identify the professional services that are responsible for each element of care. -Aid in preventing or reducing decline in the resident's functional status and/or functional levels. -Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and -Reflect currently recognized standards of practice for problem areas and conditions. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. -When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. -Care planning individual symptoms in isolation may have little, if any, benefit for the residents.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview and document review, the facility failed to ensure appropriate interventions were in place to prevent elopement for 3 of 3 residents (R1, R4, R6) who were identified as an elopement risk. This resulted in immediate jeopardy (IJ) for R1 when she was able to leave the facility when it was dark and foggy outside and was able to walk 5-6 blocks away before being found, which put R1 at likelihood for serious harm or death. The IJ began on 4/13/26 when R1 was able to elope from the facility after the facility failed to complete a comprehensive assessment for individualized interventions and level of supervision after R1 removed, then refused, replacement of Wanderguard (personal alarming safety device) on 3/29/26 and continued to display exit seeking behaviors. Additionally, the facility failed to identify and implement individualized interventions to prevent and/or mitigate risk for elopement for R4 and R6. On 4/16/26 at 5:04 p.m., the administrator, director of nursing, and vice president of clinical services were notified of the IJ. The IJ was removed on 4/17/26 at 5:00 p.m., after it was verified, the facility implemented an acceptable removal plan. However, non-compliance remained at a lower scope and severity of no actual harm, with a potential for more than minimal harm. Findings include:R1's face sheet dated 4/15/26, identified diagnoses of unspecified dementia without behavioral disturbance and depression.R1's neurology note dated 3/10/26, identified R1 was seen for a follow up on cognitive changes where her neuropsychometric (a comprehensive evaluation of cognitive, behavioral, and emotional functioning) testing suggested R1 has Diffuse Lewy Body Disease (a progressive neurodegenerative disorder characterized by cognitive decline, severe, fluctuations in alertness and detailed visual hallucinations).R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment, had delusions/hallucinations, no other behaviors, no rejection of care, no wandering, did not use a walker or wheelchair, was independent with transfer and ambulation, had two or more falls since admission with no injury, and used a wander/elopement alarm daily (Per Elopement Evaluation the device was not applied until 3/26/26).Review of R1's record identified hourly safety checks were initiated on 3/23/26, however the record did not include a corresponding comprehensive assessment that had determined the frequency safety checks were appropriate and individualized to R1's risks and safety needs. R1's elopement evaluation dated 3/26/26, identified R1 was at risk for elopement due to wandering behaviors that were likely to affect the safety or wellbeing of self/others. Wanderguard was applied. R1's March 2026 Medication Administration Record (MAR) included a physician order dated 3/28/26 to check Wanderguard (name brand for a personal safety device) function and placement every shift for elopement/wandering.Review of R1's care plan 3/26/26 through 4/13/26, did not identify an elopement focus care plan had been developed and implemented with interventions to prevent R1 from leaving the facility unsupervised. R1's progress note dated 3/28/26 at 5:40 a.m., R1 was up early parts of the shift wandering in hallways and finally laid down at 3:30 a.m. but was not sleeping. R1 took off bracelet (Wanderguard) from hand and bracelet replaced on right ankle. R1's progress note dated 3/28/26 at 10:48 p.m., R1 would not allow staff to check for bracelet on leg properly. R1's progress note dated 3/29/26 at 4:39 a.m., R1 was up early hours of the night and laid in bed around 1:30 a.m. R1 would not allow staff to touch ankles to check for bracelets. R1's progress note dated 3/29/26 at 10:59 a.m., R1 had cut off her alarm bracelet on the night shift and was found in the garbage can. R1's progress note dated 3/29/26 at 4:14 p.m., R1 took Wanderguard off and will not allow replacement.R1's progress note dated 3/29/26 at 8:51 p.m., identified R1 had cut off Wanderguard with a scissor at some point during the night last night and was found in her room and was found in the garbage and then placed in the medication cart.During an interview on 4/15/26 at 4:25 p.m., director of nursing (DON) stated R1 had an elopement evaluation completed on 3/26/26 because R1 had started to make exit seeking comments; based on the evaluation it was determined (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 was at risk for elopement and had a Wanderguard placed on 3/26/26 as an intervention to reduce the risk for elopement. However, R1 removed her Wanderguard on 3/28/26 and again on 3/29/26 and would not allow staff to reapply a new one. DON explained R1 had been on hourly checks since 3/23/26 but had not had any increase in supervision and/or alternate interventions to reduce the risk of R1 eloping after R1 removed her Wanderguard. DON further explained R1 did not have an elopement focus care plan that informed staff of R1's elopement risk and interventions until 4/15/26.R1's progress note dated 3/31/26 at 6:37 a.m., identified R1 no longer had Wandergaurd on. R1's progress note dated 3/31/26 at 3:11 p.m., identified R1 does not wear [Wanderguard]. R1's progress note dated 3/31/26 at 10:57 p.m., identified R1 did not have a Wandergaurd and refused to apply during room checks. R1's progress note dated 4/1/26 at 7:29 a.m., identified R1 refused to wear [Wanderguard].R1's progress note dated 4/1/26 at 5:43 p.m., identified R1 approached writer and asked, Are you going to leave me too. R1 then said, I want to get out of here for a couple weeks and they will not let me. Writer explained to R1 that she could go on a leave of absence with a responsible party. R1 stated, Yeah right, they will not let me go and go to hell.During an interview on 4/16/26 at 11:44 a.m., social service designee (SSD) stated she did not feel R1's comments on 4/1/26 were exit seeking in nature, however, SSD was not aware that R1 had been determined an elopement risk on 3/26/26 and if she had been aware of this she would have considered this exit seeking comments and R1 should have had additional interventions put in place. R1's progress note dated 4/4/26 at 2:06 p.m., identified R1 was confused and following nurse around the facility. R1 was talking about people disappearing and when she opens her mouth and talks, she gets herself in trouble. R1 wandered around the facility all day and went outside with other residents but did not attempt to leave the facility. R1's progress note dated 4/7/26 at 3:01 p.m., identified R1 was confused this morning, walking around facility, following nursing staff seeking reassurance. R1 seemed very nervous, with her bottom lip quivering. R1 mentioned she needed to get her taxes done and she thought the writer was going to do them for her. Writer told R1 she could not do her taxes, then R1 approached writer shortly after with similar concerns. Staff called R1's power of attorney (POA) to talk to R1 to let her know POA would take care of her taxes. R1 then expressed concerns about where she was going to live and told R1 she could remain at the facility. R1's progress note dated 4/9/26 at 4:43 a.m., identified R1 stood outside of door and stated her toilet smelled. No odor noted from toilet, but staff flushed toilet to content her. R1's progress note dated 4/10/26 at 1:17 p.m., identified R1 informed staff that she had groundhogs in her room. Staff told R1 there was no groundhogs in her room. R1 then got very close to staff members face and stated, If you don't get those groundhogs out of my room, I'm going to slit your throat. Suggested to social services that R1 be moved to the front of the facility where she can be around more people and easier seen by staff. R1's progress note dated 4/10/26 at 3:00 p.m., identified R1 had a room change. R1's progress note dated 4/10/26 at 9:53 p.m., identified R1 spent a lot of shift by the nursing station due to being upset that she had a room change. R1 was offered food, but intervention was ineffective. In review of R1's record between 3/26/26 through 4/13/26 it was not evident R1's Wanderguard was reapplied, not evident the care plan interventions were re-evaluated for effectiveness nor evident a comprehensive assessment completed to determine individualized interventions including the appropriate level of supervision frequency after R1 had continued wandering and exit seeking without a Wanderguard in place. R1's Hourly Safety checklist reviewed from 4/3/26 through 4/13/26, was not completed. The checklist identified no safety checks documented for the following days/times: -4/3/26 through 4/5/26: No safety checks completed.-4/6/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.-4/7/26: 1:00 a.m. through 5:00 a.m.; 3:00 p.m. through 11:00 p.m.-4/8/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.-4/9/26: 1:00 a.m. through 5:00 a.m.; 3:00 p.m. through 11:00 p.m.-4/10/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.-4/11/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.-4/12/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.-4/13/26: No documentation of any hourly safety checksR1's elopement incident report dated 4/13/26, identified R1 had been brought a sandwich at (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4:55 a.m., when brought R1 pudding to her room at 5:03 a.m., R1 was not in her room. Staff searched the facility and grounds, called management, and found R1 at 5:28 a.m. R1 refused to return to the facility and was sent to emergency department with law enforcement. According to the weather station in [NAME]-[NAME] Weather Station (KMNTRACY12) the temperature on 4/13/26 at 5:04 a.m., had an actual temperature of 51.4 degrees.R1's emergency department (ED) note dated 4/13/26, identified R1 had been brought to the ED after going missing at the nursing home around 5:00 a.m. and was later found in the street wandering and became combative. R1 had stated she wanted to harm herself by jumping in front of a car. R1 was orientated to name and date of birth but required orientation to place. Not oriented to date or situation. R1 stated she would never actually hurt herself. R1 was unable to provide coherent history regarding events that occurred. R1 stated she had heard and seeing things before that were not there but was unable to provide further information regarding this. R1 had a history of Lewy Body Dementia and communication with R1's behavioral health provider recommended R1 be admitted to a geriatric psychology facility for re-evaluation and stabilization.During an interview on 4/15/26 at 12:58 p.m., nursing assistant (NA)-F stated R1 had a Wanderguard put on her a few weeks prior to her elopement and was told she had removed her own bracelet on 3/29/26 and refused to have another bracelet applied. NA-F stated they were not doing any additional interventions to mitigate the risk of R1 eloping such as increase in supervision especially since she had cut off her wander bracelet. NA-F explained R1 would always wander in the hallways through the day but was unsure if she had attempted to leave the facility prior to leaving on 4/13/26, however, R1 would make comments that she wanted to leave the facility at times. NA-F stated R1 had behavior changes in the past week prior to her eloping such as hiding around corners and watching staff closely and just acting differently. NA-F explained she had been instructed to read a handout on elopement that was at the nursing station but had not had time to read it yet. NA-F could not articulate where to locate how to identify if a resident was at risk for elopement but would reference the care plan/Kardex to help her identify which resident was at risk.During a phone interview on 4/16/26 at 6:38 a.m., licensed practical nurse (LPN)-A stated R1 had been moved to a different part of the building on 4/10/26 due to her hallucinating in her old room. R1 had been seeing groundhogs in her room and by moving R1 the facility thought it might help with her hallucinations. LPN-A explained she was the night nurse on 4/13/26 and R1 had been wandering in the hallways and had been given a snack around 4:30 a.m. then R1 went back to her room. LPN-A stated at around 4:55 a.m., R1 had returned to the nursing station to ask for something to eat. LPN-A then offered to get R1 some pudding and then R1 began to walk down the hallway in the opposite direction of her room, LPN-A then redirected R1 to the direction of her room and told R1 she would bring her the pudding to her room. LPN-A did not make sure R1 went to her room, she went to the kitchen to get ice water and pudding for R1 while NA-A went to go and answer a call light for another resident. LPN-A then went to R1's room around 5:03 a.m. and noticed R1 was not in her room. LPN-A then immediately had NA-A and NA-B begin to search for the facility for R1, but they were unable to locate R1. LPN-A then called 911 and had NA-A go outside to search around the building for R1. When NA-A could not locate R1 she had NA -B take her car to begin driving around the town for R1. LPN-A stated it was still dark out and the weather was foggy that morning. LPN-A stated NA-B had called her around 5:30 a.m., to say she had found R1 about 5-6 blocks away on the street and that R1 refused to return to the facility with her. LPN-A then sent NA-A to drive to the location of NA-B to assist. LPN-A explained neither NA-A nor NA-B could get R1 to return; R1 had become combative and began striking out at staff. LPN-A then sent other staff to attempt to get R1 to return to the facility.During an interview on 4/15/26 at 3:22 p.m., NA-A stated he was aware R1 had removed her Wanderguard bracelet on 3/29/26 and had refused to allow another bracelet to be applied, however, R1 had been on hourly checks since 3/23/26, but had not been doing the checks consistently during his shifts and would but he normally just kept a close eye on R1. NA-A was unaware of any other elopement intervention in place for R1 to prevent her from eloping. NA-A stated he worked the night shift on the day that R1 eloped from the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. R1 had been awake that night and came to the nursing station around 4:30 a.m., asking for something to eat. Licensed practical nurse (LPN)-A had given R1 a sandwich and then R1 returned to her room. At around 4:55 a.m., R1 came back to the nursing station and asked for something else to eat at which time, LPN-A asked R1 if she would like some pudding. R1 did not respond but shrugged her shoulder and began walking in the opposite direction of her room, at which time LPN-A directed R1 in the opposite direction towards R1's room. As R1 was walking in the direction of her room, LPN-A headed towards the kitchen to get ice water for another resident and pudding. NA-A answered another resident's call light before R1 was seen entering her room. When NA-A completed answering the other resident's call light he was notified by LPN-A that R1 was missing, and he began to search the building to see if R1 could be located. NA-A then searched all the room and then began looking outside around the building but could not locate R1. LPN-A had given instructions to NA-B to get in her car and begin to search the town for R1. NA-B called NA-A at around 5:30 a.m., to inform him she had located R1 but needed additional assistance because R1 refused to go with NA-B. NA-A then got in his car and went to the location where R1 and NA-B were at which was about 5-6 blocks away. R1had shoes and a zip up hoodie when he got to her and still refused to go with either NA-A and NA-B and began to strike out at NA-A. NA-B and NA-A remained close by R1 and continued to try and convince R1 to come with them back to the facility, but R1 continued to refuse. At around 5:45 a.m., LPN-B arrived and attempted to get R1 to return to the facility but R1 continued to refuse. LPN-B then directed NA-A and NA-B back to the facility.During an interview on 4/15/26 at 3:01 p.m., NA-B was aware R1 had a Wanderguard placed, however, R1 had removed it and did not allow staff to replace it. R1 wandered around the facility at night and would sit at the nursing station to visit with staff. R1's cognition had been getting worse; she had been seeing things like groundhogs so on 4/10/26 she was moved to a different room to see if that would help. NA-B was unaware if R1 was on hourly checks and had not been documenting any hourly checks. NA-B stated she was working the night shift on 4/13/26 when R1 eloped from the facility. NA-B had received a call on the walkie talkie around 5:00 a.m. from LPN-A giving her direction to search the facility for R1 because she was missing from her room. NA-B searched her wing and could not locate R1. About 5:10 a.m., she was told by licensed practical nurse (LPN)-A to get in her car and drive around town to see if she could locate R1. NA-B stated it was dark and foggy outside when she got in her car and began driving slowly around town. Around 5:30 a.m., she found R1 walking about five or six blocks from the facility. NA-B had attempted to get R1 to return to the facility with her but R1 refused, so NA-B called the nursing home and asked for another staff member to assist her. R1 continued to walk toward the main street and continued to refuse to come back to the facility. During an interview on 4/16/26 at 11:44 a.m., social services designee (SSD) stated the facility had moved R1 on 4/10/26 to a different room on a wing closer to the nursing station to keep a better eye on R1 because her cognition had begun to decline and she had been having more hallucinations in her previous room. The move had not been based on her elopement risk; nursing had been attempting to get R1 to move to her current location by the nursing station for some time. SSD stated she had been contacted on 4/13/26 around 5:34 a.m., SSD was informed R1 had eloped from the facility. SSD walked to the location where staff were at with R1. SSD stated she remained with R1 who had continued to refuse to come with staff back to the facility. SSD stated R1 had continued to walk across a railroad track and stated, she wanted to just walk in front of train and end it all. SSD explained she remained walking with R1 who then walked across a busy highway and finally sat on a bench in front of the gas station when the local police arrived and took R1 to the ED.During a phone interview on 4/16/26 at 2:42 p.m., medical director (MD) stated any resident identified at risk for wandering/elopement should have appropriate interventions in place to mitigate the risk of the resident eloping. MD explained by R1 being allowed to elope on 4/13/26 this put her at risk for serious harm, injury, or even death. During a follow up phone interview on 4/16/26 at 4:26 p.m., MD explained R1 had worsening cognition due to her Lewy Body Dementia and was not able to make safe decisions and this was why she was in the nursing home in the first place. During an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interview on 4/15/26 at 4:25 p.m., DON explained that after R1 had eloped they had completed a re-assessment of all residents on 4/14/26 for elopement risk, reviewed/revised care plans, and provided began providing education to the nursing staff on elopement and what to do if a resident elopes, but did not provide any education on what to do if a resident removes a Wanderguard. Although the DON reported after R1 eloped on 4/13/26, all residents were re-assessed for elopement risk, care plans were reviewed/revised, and staff were educated, the facility failed to ensure the identified elopement risks for R4 and R6 were incorporated into individualized care plan interventions that were implemented, and clearly communicated to staff, and failed to ensure consistent monitoring. -R4's face sheet dated 4/20/26, identified diagnoses of dementia,R4's quarterly MDS dated [DATE], indicated R4 had moderate cognitive impairment, physical and verbal behaviors that occurred one to three days, no rejection of care, had no impairment on upper extremities, used a wheelchair, was dependent with wheelchair mobility, had no wandering, had falls since admission, and did not use a wander/elopement alarm.R4's Elopement/Wandering focus care plan dated 12/19/24, identified R4 was low risk for Wandering/Elopement.-Identify if there are triggers for wandering/eloping. (dated 12/20/24) R4's progress note dated 3/5/26 at 10:05 a.m., identified R4's call light was on, however R4 was headed towards the lobby and the nursing station. R4 stated he wanted to get in the recliner, staff told him they needed to get a second person for assistance. R4 stated he wanted to get out of the f----ing place.R4's progress note dated 3/22/26, identified R4 became upset when his wife went home and stated, he is stuck here, and she gets to leave.R4's Elopement Evaluation dated 3/27/26, identified R4 was at risk for elopement due to verbally expressing desire to go home, pack belongings or stayed near the exit door.R4's Elopement Evaluation dated 4/14/26, identified R4 was at risk for elopement due to verbally expressing desire to go home, pack belongings or stayed near the exit door. R4's care plan did not include individualized care plan with interventions to mitigate the risk of elopement. During an interview on 4/16/26 at 9:22 a.m., LPN-B stated R4 gets upset at times that he cannot leave the facility when his wife leaves after visiting and makes exit seeking comments after she leaves. LPN-B stated she was not aware if R4 had been determined an elopement risk, however, LPN-B stated R4 was able to propel himself in his wheelchair throughout the facility at times and could easily attempt to leave the facility unaccompanied.During an observation on 4/16/26 at 9:45 a.m., R4 was seated in his wheelchair in the day room and was seen propelling himself in his wheelchair around the room. During interview on 4/16/26 at 12:39 p.m., NA-D stated that she referred to a resident's care plan/ Kardex to identify if a resident who wanders and if they were at risk for elopement and what interventions were in place. NA-D stated R4 could wheel himself in his wheelchair and could push the handicap button and get out the door if he wanted to. NA-D stated R4 would get upset and state he wanted to go home with his wife visited and left the building. NA-D stated staff redirected R4 and reminded him why he could not go home with his wife. NA-D stated R4's mood was better, since R4 was more used to staff. NA-D reviewed R4's Kardex and confirmed the Kardex did not identify R4 as an elopement risk, no triggers, nor a listing of interventions to mitigate elopement. During an interview on 4/16/26 at 1:25 p.m., assistant director of nursing (ADON) stated R4 had been identified as a risk for elopement, however, ADON believed R4 would not be strong enough to propel himself in his wheelchair to get himself outside and did not have any additional interventions like a Wanderguard applied to alert staff if he attempted to leave. R6R6's face sheet dated 4/20/26, identified diagnoses of dementia, Parkinson's disease, and diabetes.R6's admission MDS dated [DATE], identified R6 had moderate cognitive impairment, no behaviors, no rejection of cares, no wandering, used a walker, was independent with transfers, independent with ambulation, and did not use a wheelchair.R6's Elopement Evaluation dated 3/31/26, identified R6 was at risk for elopement due to a history of elopement or an attempted elopement while in home; R6 had been admitted within the past 30 days and is not accepting the situation. Intervention selected to engage in purposeful activity.R6's Wandering/Elopement care plan dated 3/31/26, identified R6 was at risk for wandering/elopement. Goal to not leave the facility unattended with a corresponding intervention (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/20/2026
NAME OF PROVIDER OR SUPPLIER Valley View Manor Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 200 East Ninth Avenue Lamberton, MN 56152	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	directing staff to engage resident in purposeful activity. R6's progress note dated 3/31/26, identified R6 had poor safety awareness on admission.R6's progress note dated 3/31/26, identified R6 as an elopement risk and utilized wander elopement alarm. Review of R6's record revealed no indication of Wanderguard placement until 4/15/26. R6's progress note dated 4/1/26, identified a resident preference evaluation completed. R6 identified it was very important to him to go outside to get fresh air when the weather is good. R6's progress note dated 4/1/26 at 4:30 a.m., identified R6 was up one time during shift and asking for a snack and then ambulated to the south side of the building to stretch his legs a little.R6's Elopement Evaluation dated 4/14/26, identified R6 was at risk for elopement due to verbally expressed the desire to go home, packed belongings to go home, or stayed near the exit door, recently admitted to the facility within the past 30 days and is not accepting the situation. Intervention selected to engage in purposeful activity and monitor location frequently. R6's elopement evaluation did not identify history of elopement that was identified in R6's 3/31/26 elopement evaluation. R6's care plan did not identify any revisions to his care plan to mitigate the risk of elopement.R6?s progress note dated 4/14/26 at 6:18 p.m., identified R6 stated he had a home to go to/live in. Wanderguard attempted to be placed on 4/14/26, however, R6 refused. Will attempt to place Wanderguard again on 4/15/26. R6's record did not identify any additional elopement prevention interventions to R6's care plan since R6 refused to have a Wanderguard be applied.R6's progress note dated 4/15/26 at 10:00p.m., identified a Wanderguard placed on R6's left wrist.R6's wandering/elopement care plan revised on 4/15/26 to include the following: -Identify wandering/elopement de-escalation behaviors, Wanderguard placed on 4.15.26. -Identify if there are triggers for wandering/eloping -R6 does have Wanderguard in place. During an interview on 4/16/26 at 9:22 a.m., LPN-B stated R6 has wandered throughout the facility since admission and also made exit seeking comments about wanting to go home to get his back brace. LPN-B explained she was not made aware R1 was an elopement risk until she was asked to place a Wanderguard on R6 on 4/15/26. LPN-B further explained R6 could have easily eloped from the facility prior to 4/15/26 because he was independent in the facility with only his walker and staff may not have seen him leave.During interview on 4/16/26 at 12:39 p.m., NA-D stated R6 was admitted to the facility a few weeks ago and would wander in the hallways independently with a walker. NA-D explained R6 made comments about wanting to go home at times. NA-D reviewed R6's Kardex and was unsure of R6's triggers for Wandering and/or elopement.During an interview on 4/16/26 at 1:01 p.m., ADON stated R6 was identified as an elopement risk on admission because R6 had eloped from a previous facility. ADON explained she determined R6 should have a Wanderguard bracelet placed on admission, however, the facility did not have any Wanderguard bracelets at the time of admission that were not expired, and the facility was unable to place a bracelet on R6. ADON further explained the facility had not put any additional interventions in place to prevent R6 attempting to leave the facility unsupervised and should have put things in place prior to placing the Wanderguard on 4/15/26.During an interview on 4/16/26 at 12:46 p.m., NA-C stated she was aware R1 was an elopement risk but did not identify R4 nor R6 as an elopement risk and was unsure of any interventions to mitigate the risk of R4 or R6 from leaving the facility unattended. NA-C stated Wanderguards were a replacement for resident supervision and if a resident had a wander bracelet they would not need to be supervised as much. Review of the facility's Safety and Supervision of Resident's Policy undated, identified the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities.Individualized, Resident-Centered Approach to Safety-Our individualized, resident-centered approach to safety addresses safety and accident hazards for individualized residents.-The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individualized residents.-The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.-Implementing interventions to reduce accident risks and hazards shall include the (continued on next page)

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