STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Healthcare & Rehab	510 East Cedar Street Houston, MN 55943

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on interview and document review the facility failed to complete a comprehensive assessment, monitor, and notify the physician for a sudden change in mental and physical status for 1 of 3 residents (R1) who had a change in condition. The deficiency was identified as past non-compliance and issued at Immediate Jeopardy. The Immediate Jeopardy (IJ) began on [DATE], when R1 demonstrated changes to mental status, speech, and mobility in which licensed nursing staff failed to comprehensively assess, monitor, and notify the physician. The Administrator and Director of Nursing (DON) were notified of the IJ on [DATE] at 5:30 p.m. The facility had implemented immediate corrective action on [DATE] to prevent recurrence, the IJ was issued at past non complinace. Findings include: R1's face sheet dated [DATE], identified R1 was admitted to the facility on [DATE], with diagnoses of type 2 diabetes, obstructive sleep apnea, weakness, and falls. R1 had physical and occupational therapy. R1's comprehensive SLUMS (St. Louis University Mental Status) assessment dated [DATE], identified R1 had a score of ,d+[DATE], which indicated mild cognitive impairment. R1's temporary care plan dated [DATE], identified R1 was stand by assist (SBA)/contact guard assist with walking with a walker. R1's point of care (POC) documentation dated [DATE], identified at 10:41 a.m., R1's balance was always steady from seated to standing, walking, turning around, moving on and off the toilet, and transferring between surfaces. R1's progress note dated [DATE] at 2:47 p.m., identified R1 was alert and orientated and able to let needs be known to staff. Assist of one with gait belt for transfers, toileting, bathing and activities of daily living. R1 participated with physical and occupational therapies for strengthening, needed staff assistance with meals as she had problems with holding a glass. Planed to return home after rehab. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's progress note dated [DATE] at 10:00 p.m., was a late progress note entered by registered nurse (RN)-A for 7:04 p.m., included, This nurse was called into residents room as she got weak with transferring in the bathroom and staff lowered her to her knees without incident. Staff attempted several times to assist resident back to her feet and remained on her hands and knees. This nurse asked staff what to do and one staff stated to call 911. This nurse called 911 and told them that staff was having a difficult time assisting resident from the floor. By the time the ambulance arrived staff was able to get her to lay flat so the full body mechanical lift was able to be used. This nurse apologized to ambulance crew. She was put to bed, and she is stable at this time. Review of R1's record dated [DATE] did not include any documentation of comprehensive post fall assessments, physical condition, mental status, and vital signs. Review of R1's record identified no indication that R1 had supper, snacks, or fluids provided on [DATE] from 2:00 p.m.-10:00 p.m. R1's ambulance run report printed [DATE], identified emergency medical services (EMS) arrived on scene at 7:13 p.m. and were informed patient was in bed and did not need medical attention. EMS clarified the statement, and the response remained no, medical attention was not necessary. EMS left scene at 7:15 p.m. R1's call light report dated [DATE], identified on [DATE] at 9:30:24 p.m. R1's call light was activated, the call light was cancelled after 37 seconds. Then at 9:31:17, R1's call light was again activated and cancelled after 37 seconds. At 9:31:17 p.m., R1's call light was turned on, and remained on for 24 minutes and 24 seconds, shut off time was 9:55:41 p.m. R1's progress note dated [DATE] at 10:59 p.m., identified RN-A was called to R1's room for R1's passing. Nursing assistant (NA) had went to the room for rounds and R1 had passed away in her sleep. During an interview on [DATE] at 1:38 p.m., trained medication aide (TMA)-A stated she worked with R1 on [DATE] during the day. R1 was perfectly fine, could independently move and staff would just walk next to her to use the bathroom. During an interview on [DATE] at 2:07 p.m., TMA-D stated on [DATE] around 2:00 p.m., she was able to transfer R1 to the toilet independently with little to no difficulty. Then when R1 was done, TMA-D attempted to stand R1 back up but R1 was not able to at all. TMA-D stated it took three staff members to stand R1 to get her back into her wheelchair. TMA-D stated, she was out of it, R1 could answer questions but could not follow directions. When R1 was directed to let go of the grab bar, she held on tighter but told us she had let go, when she did not. TMA-D stated she reported R1 needing more assistance to the on-coming nurse. R1's progress notes and vital sign record did not identify any documentation of assessment pertaining to R1's episode as reported by TMA-D. During an interview on [DATE] at 3:00 p.m., physical therapist assistant (PTA)-A indicated the first time he had worked with R1 was sometime after lunch on [DATE]. PTA-A reported after a few exercises R1 became tired and wanted to go to bed. Since PTA-A had not worked with R1 before, he was not aware that R1's tiredness was a change from her baseline. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:59 a.m., occupational therapy assistant (OTA)-A stated she had first worked with R1 on [DATE]. On [DATE], OTA-A indicated R1 demonstrated changes since [DATE]'s session. On [DATE], at 3:58 p.m. OTA-A started R1's session in her room. When OTA-A attempted to have R1 work on arm exercises, R1 could not follow direction, R1's eyes started closing, and she was not able to articulate her speech. Around 4:10 p.m., R1 told OTA-A she was okay but stuck out her tongue while trying to talk three different times. After the therapy session, OTA-A left R1's room and notified infection preventionist (IP)-A something was wrong with R1, but IP-A directed OT-A to notify registered nurse (RN)-A. When OTA-A notified RN-A of R1's condition, RN-A told her R1 had influenza, and nothing could be done. OTA-A stated RN-A then put on her coat and went outside and did not go to R1's room to assess her. During an interview on [DATE] at 11:24 a.m., IP-A indicated R1 did not have influenza. OTA-A had came to IP-A's office and reported R1 did not seem like herself. Nothing the therapist told her sounded like it was infectious related, so she directed the therapist to tell RN-A. R1's progress notes and vital sign record did not identify any documentation of assessment pertaining to R1's episode as reported by OTA-A. During an interview on [DATE] at 2:51 p.m., nursing assistant (NA)-B stated on [DATE] around 7:00 p.m., she assisted R1 during a transfer in the bathroom from her wheelchair. During the transfer R1 began shaking and was too scared to sit down on the toilet because she was just too weak. NA-B then proceeded to lower R1 to the floor and requested a nurse over a walkie talkie. When RN-A came into R1's bathroom, she asked R1 if she was in pain, but did not perform any vital signs. RN-A then proceeded to call an ambulance. NA-A, NA-B and NA-D then used a total mechanical lift to assist R1 off the floor and placed R1 back in bed. During an interview on [DATE] at 5:21 p.m., NA-D indicated she had worked the evening shift on [DATE] and had not worked with R1 prior. NA-D had assisted R1 to get off the toilet prior to supper. R1 was strong, but slow and unsure of her steps. R1 ate normal at supper. Then around 7:00 p.m. she had become aware R1 was on the floor by a walkie talkie call by NA-B. When she entered R1's room, R1 was on the floor in the entrance of the bathroom on her hands and knees very anxious and shaking. NA-D then came into R1's room and even though R1 was anxious, shaking, and no assessment completed, the NAs told R1 to crawl out of the bathroom so they could assist her to roll onto the lift sling, and transfer her back to her bed. While R1 was on the floor she was not right, not comprehending well, not cooperating, a lot of anxiety, breathing heavy, and shaking. NA-D stated when R1 was on the floor, RN-A never came into the room, but stood in the doorway watching. RN-A left the room, but NA-D was not sure where she went or what she was doing. NA-D stated RN-A did not seem right that night, she was not fit to work and struggled to breath [because of respiratory virus]. NA-D recalled around 8:00 or 8:30 p.m., she answered R1's call light. R1 wanted to be re-adjusted in bed because she had foot pain and wanted her head of the bed elevated. NA-D thought R1 was ok at that time. During a follow-up interview on [DATE] at 2:49 p.m., NA-D stated she did not remember going into R1's room to answer the call light on [DATE] at 9:30 p.m. NA-D was certain the last time she had interacted with R1 was around 8:30 p.m. when she had boosted her up in bed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:47 a.m., NA-A indicated prior to [DATE], R1 was alert and orientated, not confused, and walked with a walker with only supervision. On [DATE], NA-A worked the evening shift. At approximately 7:00 p.m. NA-A overheard on his walkie-talkie NA-B requesting RN-A's assistance in R1's room. NA-A went from the hallway he was working on to R1's hallway past the central nurse's station where RN-A was sitting. NA-A told RN-A that NA-B was calling her to R1's room for help. NA-A entered R1's room and found R1 half in and half out of the bathroom doorway propped on her wheelchair, with NA-B on her knees, attempting to help R1. RN-A came to the room and observed the situation. R1 was grunting and groaning but not talking much and told the NA's she felt a bit off. NA-A directed RN-A to call 911 as R1 was not participating much and both NAs were not sure if they could get R1 into a position where they could move her to her bed. RN-A left the room without assessing or assisting R1. NA-A and NA-B were able to get R1 situated into a crawling position and eased her into the room and out of the bathroom where they had her lay down and used a mechanical lift to get her back into bed. RN-A returned to the room as NA-A and NA-B were moving R1 to the bed. R1 was verbally responding at that time. NA-A stated he told RN-A that the paramedics should still check out R1 as she still was not herself because normally R1 was able to walk by herself with just supervision. RN-A did not take the lead in the situation and was asking NA-A what to do. During a phone interview on [DATE] at 10:51 a.m., NA-C stated she worked the evening shift on [DATE], that was the first time NA-C had ever laid eyes on R1 and had no previous encounters. NA-C answered R1's call light on [DATE], at 9:55 p.m. NA-C recalled she had knocked on R1's door that was open, R1 did not respond so she entered the room. NA-C entered the room, knocked on the bedside table, and turned the overhead light on. When she turned on the light, she knew R1 was deceased . R1 had her mouth open and emesis trailing from her mouth and into her hair. NA-C called over the walkie-talkie to have RN-A come to the room. RN-A came into the room, looked at R1, with a blank look on her face turned to NA-C and said, what do I do?. NA-C responded that she did not know as she was not a nurse. NA-C stated she was positive RN-A never touched R1 to assess vital signs to verify death. NA-C and RN-A left the room together. RN-A returned to the desk and called the director of nursing (DON). During a follow-up interview on [DATE] at 9:00 p.m. NA-C stated the only staff that were working after 9:00 p.m. was herself, NA-D, and RN-A. NA-C had not answered any other call lights aside from the one at 9:55 p.m. and did not know how the call light was reset the other two times at 9:30 and 9:31 p.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 9:26 a.m., RN-A stated she had worked the evening shift on [DATE]. RN-A could not recall if TMA-A had notified her that R1 required more assistance. RN-A did remember occupational therapist had notified her R1 was not herself around 4:30. RN-A went to R1's room, R1 was in bed, looked tired, but did not appear in any distress. RN-A asked R1 how she was doing. R1 reported to her she was doing ok and was just tired. RN-A took R1's blood sugar and it was a little high, RN-A administered scheduled insulin, did not complete any further assessments, and did not take R1's vital signs. R1 then ate most of her dinner. Around 7:00 p.m. R1 needed to be lowered to the floor in the bathroom. RN-A went to R1's room, she was on the floor with the NAs, RN-A only asked R1 if she was ok, R1 said she was ok and was not injured. RN-A did not perform any other assessment but called the ambulance because NAs could not get R1 off the floor. By the time the ambulance arrived, NAs had been able to get R1 off the floor using a full body mechanical lift. RN-A dismissed the ambulance without evaluating R1. After R1 was transferred back into bed, RN-A took R1's blood sugar, it was in the mid 100's, but did not record it into the medical record and did not complete any further assessments. RN-A stated the next time she went into R1's room was to administer scheduled medications between 8:00 and 8:30 and thought R1 was fine. RN-A indicated after each time she was notified by staff of R1's condition, she went into R1's room, but R1 was not demonstrating any symptoms that any of the staff had reported to her. RN-A did not go beyond asking R1 if she was ok and relied solely on R1's self-reports. RN-A indicated only relying on R1's self-assessment was an error in judgment. During an interview on [DATE] at 1:57 p.m., DON stated that she had worked during the day on [DATE] and also came back and worked the night shift. DON indicated she had received a call from RN-A while driving back to the facility, R1 had passed away. When she got to the facility, she had thought RN-A was scattered and sent her home. When DON was reviewing R1's record she had identified RN-A had prematurely documented the required skilled charting at the beginning of shift around 2:30 p.m. instead of at the end of her shift. Further identified the lack of assessments throughout the shift. DON stated there was nothing going on in the facility on [DATE] that would have taken RN-A's time away from assessing R1. DON was unsure why RN-C thought R1 had influenza. It was DON's expectation that when a resident exhibits a change in condition such as needing a higher level of assistance, cognitive/mental status changes, not feeling well, falling, and death that vital signs and comprehensive assessments be completed and increased monitoring be implemented and documented. Additionally, the physician should be notified with changes for further treatment needs. After the incident, DON terminated RN-A's employment and provided staff education on the aforementioned expectations. During a phone interview on [DATE] at 2:27 p.m., medical doctor (MD)-F stated any change in mental status would be considered emergent as it could be an infection, stroke, or cardiac. The resident should be brought to the emergency department for an evaluation and treatment. MD-F stated that when R1 was not able to respond to questions correctly, needed a higher level of assistance than normal the nurse should have evaluated R1 and notified him to the change of condition. In R1's case her symptoms could have been related to a stroke, hypoglycemia, hypercapnia, or heart issues that need to be taken care of. The outcome may have been different if R1 had been sent to the emergency department. The failure to complete assessment on those type of symptoms assessed could put any resident at risk for serious injury, harm, and death, which occurred with R1. The facility policy Change in a Resident's Condition or Status dated [DATE], identified the nurse will notify the residents attending physician or physician on call when there has been a(an): (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. significant change in the resident's physical/emotional/mental condition a significant change of condition is a major decline or improvement in the resident's status that: a.Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions b.Impacts more than one are of the residents health status c.Ultimately is based on the judgement of the clinical staff and the guidelines outlined in the resident assessment instrument. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. The nurse will record in the resident medical record information relative to changes in the residents medical/mental condition or status. If a significant change in the residents physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required. The past non-compliance IJ that began on [DATE], and was removed on [DATE], when it was verified the facility implemented the following: -Immediately sent RN-C home pending further investigation then was terminated from employment. -Educare on change of condition assessment for all nurses with competency on [DATE] -Change of condition education is assigned for completion -All licensed staff were given written communication on change of condition-notification to the provider. -Education on death policy [DATE] -Interviews conducted with licensed and unlicensed staff conducted confirmed competency of the facility process.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51576 Based on interview and document review, the facility failed to process and implement bilevel positive airway pressure (BIPAP) order for 1 of 1 resident (R1) reviewed for respiratory care. Findings include: R1's face sheet dated 1/31/25, identified diagnoses of congestive heart failure (a condition where the heart does not pump blood as well as it should), atherosclerotic heart disease (a condition where fatty deposits build up in the arteries of the heart), obstructive sleep apnea (condition of intermittent airflow blockage during sleep), R1's outside physician orders for admission to the facility dated 1/8/25, included a BIPAP was ordered for a diagnosis of obstructive sleep apnea (condition of intermittent airflow blockage during sleep). R1's electronic health record for physician orders between 1/9/25 through 1/13/25, did not identify the order had for BIPAP had been transcribed into the facility record. Further treatment administration records did not identify R1 received the BIPAP therapy between the dates identified. R1's baseline care plan dated 1/9/25, did not identify R1 required BIPAP therapy and the condition in which is was ordered for. R1's progress notes from 1/9/25 to 1/13/25, did not identify a physician was notified R1 did not BIPAP machine nor evident of communication with R1 or resident representative that the facility did not have a BIPAP available for use. Further the record did not include ongoing assessments and monitoring for signs and symptoms related the diagnosis for which it was prescribed and/or possible symptoms if any related to the omission of BIPAP therapy. During an interview on 1/27/25 at 4:45 pm., licensed practical nurse (LPN)-A stated she did not recall if R1 had a BIPAP while she was here and it and if she had an order, it would have been placed in the treatment administration record (TAR) for the nurses to sign off each night. LPN-A indicated R1's family would have had to have brought the device from home to use at the facility. During an interview on 1/29/25 at 2:12 p.m., the director of nursing (DON) stated she was aware R1 had a physician order for BIPAP on admission on 1/9/25, however did not have a BIPAP in the facility and family would need to bring one in. DON stated the physician was not notified of R1 not having a BIPAP available and stated family had not been contacted to bring one from home. During an interview on 1/28/25 at 2:27 p.m., R1's physician (MD)-F stated when another provider saw her in November of 2024, he became aware R1 was not tolerating her BIPAP and was unsure of what was in that providers documentation for that visit. MD-F stated if a person needs a BIPAP and did not use it they would have snoring, gasping for air and could be sleepy during the day. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated policy on BIPAP identified BIPAP use requires physician orders, resident's medical history, diagnosis, and oxygen need must be reviewed before initiation, and resident and/or responsible party must provide informed consent.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 49616 Based on observation, interview, and record review the facility failed to ensure a complete wireless call light system in which staff were provided with functioning devices in their possession. This had the potential to affect all 33 residents at the facility. Findings include: During a phone interview on 1/29/25 at 9:26 a.m., registered nurse (RN)-A stated the facility's call light system was the worst she had ever seen. The call lights could not be heard and could not tell if they were going off unless she was in the hallway looking at the thin display bar that identified which call lights were going off. During an interview on 1/29/25 at 11:31 a.m., nursing assistant (NA)-E stated the call lights show up on the scroll board that showed the room number and bed 'A' or 'B'. The board makes one high pitched beep when a call light was activated. If there was more than one call light on, the board would scroll through the ones activated in the order that they were activated. The board did not identify how long the call light was activated for. The call system was separated by wings so the board located on each wing only showed the call lights that were activated on each hall. During an observation on 1/29/25 at 11:43 a.m., no scroll board was located in the transitional care unit suites. A scroll board was located outside of the suites at the end of the two other hallways. During an interview on 1/29/25 at 2:12 p.m., director of nursing (DON) stated when residents are admitted to the transitional care suites she alerts them that their call light may take longer to be answered. These residents would be directed to put their light on when they think they may have to use the bathroom instead of when they do have to use the bathroom. At 2:58 p.m., DON went to the infection preventionist (IP) office and pointed to a computer that had call light system software installed on it. DON indicated the computer was showed how long the call lights were going on, did not sound an alert with call light activation, and was unaware if the computer could be moved. The IP's office was locked after business hours and not accessible to floor staff. During an interview on 1/29/25 at 1:09 p.m., Administrator indicated the facility had a wireless call light system that used pagers to alert staff of call light activation, however the facility was not using the pagers. The call light system did not alert to the walkie-talkies that staff used for communication. The staff would know a call light was on by reading the boards in the hallways. During a phone interview on 1/31/25 at 8:39 a.m., call system employee (REP)-A stated the wireless system is complete with pagers/walkie talkies. The facility utilized pagers at one point, but had not ordered any since late 2022. The facility needs to have a functioning device that the employees would carry on them while they were working to alert them of an activated call light. The facility Residents Call System dated 9/22, identified residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. 3. The resident call system remains functional at all times.