STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement appropriate safety measures per facility policy for allegations of abuse and neglect for 1 of 1 resident (R3) and 1 of 1 staff nurse aide (NA)-B. Findings include: Review of the 8/14/20, State Agency (SA) report filed at 2:17 p.m., identified on 8/13/20, nursing assistant (NA)-B picked up a torn up brief and threw it back onto R3 who had torn it off himself. NA-B pushed R3 in his chest area and put R3 in his room with door closed. NA-B had been suspended pending the investigation. At time of survey NA-B had returned to work on 8/19/20, after she reviewed of the facility Abuse policy, before the facility investigation had concluded. Interview on 8/19/20 at 10:29 a.m., with NA-B identified she had been suspended on 8/14/20 at 8:30 a.m., and returned to work on 8/19/20. The administrator contacted NA-B on 8/18/20, to inform her she was able to return to work after she reviewed the Vulnerable Adult and Abuse Policies. NA-B completed the policy review on 8/18/20 at 4:30 p.m. After retuning to work, she was not required to work under any supervision, and no additional training was required of her prior to returning to work. Interview on 8/19/20 at 11:03 a.m., with social worker designee (SW) identified the incident was reported to her on 8/14/20 at 8:10 a.m. NA-A reported witnessing NA-B throw shredded pieces of incontinent product on R3 and push on R3's chest forcefully place R3 in his room and shut the door. NA-A also witnessed and reported NA-B held R3's arms on his chest. NA-A identified an activity aide (AA)-A also witnessed this. SW identified after she was told this information she reported the allegation to the administrator and was instructed to immediately suspend NA-B and start an investigation. The SW identified she had reported the allegation to the administrator, SA, and ombudsman on the same day it was reported to her. The family was not updated because she wanted to finish interviews first. The SW identified the process for reporting staff to resident abuse was to be reported within 24 hours. The facility had 5 days after submitting the alleged abuse to complete and report their investigation findings. Interview on 8/19/20 at 12:17 p.m., with the administrator identified NA-B was able to return to work on 8/19/20 after she completed review of abuse policies with the social worker which she did on 8/18/20. The administrator confirmed there no further training provided to NA-B and no additional safeguards to prevent abuse were put into place upon her return to work. Interview on 8/19/20 at 3:05 p.m., with activity aid (AA)-A identified she witnessed NA-B pick up brief pieces and throw it in R3's lap. R3 became upset and threw it back towards NA-B. AA-A identified she was unsure if the charge nurse was notified about the incident, and she had not reported it to anyone. Interview on 8/19/20 at 3:44 p.m., with the director of nursing (DON) identified she had been on vacation when this incident occurred but read the notes when she returned. NA-B was suspended until the investigation was completed. She identified the facility reviewed the allegation with their consultant and determined NA-B was able to return to work following re-training on abuse policies. DON confirmed the incident was witnessed by two staff and was surprised it happened. NA-B had a history of [REDACTED]. The DON agree that placing torn incontinent product on a resident was inappropriate, and pushing a resident into their room and closing the door could be considered seclusion. The DON was aware the administrator discussed the allegations with NA-B in length. NA-B acknowledged the allegations were serious but felt the allegations were inaccurate. The administrator educated NA-B to step away from a distressed resident to let them cool down or seek assistance from another staff member if she was unable to assist R3. Interview on 8/20/20 at 9:06 a.m., with the medical director (MD) identified if there were two witnesses and NA-B denied it happened. The facility need a process or policy to ensure all staff receive education regarding recognizing and managing behaviors when providing care to vulnerable adults. MD expected facility abuse policies and procedures included a process to educate and supervise staff if they returned to work after investigations of alleged abuse had been thoroughly investigated. Interview on 8/21/20 at 9:00 a.m., with the DON identified the MD contacted the administrator on 8/20/20. Written warnings were issued to the two staff that witnessed incident for failure to report allegations of abuse timely. NA-B was to have been supervised for two weeks with a performance review following the supervisory period. Her expectation was if staff witnessed or suspected any type of abuse they were expected to report abuse allegations to their supervisor immediately. Any supervisor receiving an allegation of abuse was to report the allegation immediately to the DON or the administrator. The facility DON, administrator, social services, and our consultant were responsible to determine whether an allegation was reportable to the SA. The DON identified If there was harm the facility would report an allegation within two hours, otherwise allegations were reported within twenty-four hours. The DON was unaware of the requirement for reporting was immediately, but within two hours for any allegation of abuse regardless if there was harm. Interview on 8/21/20 at 9:10 a.m., with the SW identified that the facility meets with the interdisciplinary team to determine if an allegation was to be reported to the SA. Review of the undated, Superior Healthcare Management Minnesota Region Abuse Prevention Plan identified the policy lacked guidance or safety measures for staff allowed to return to work following suspension related to allegations of abuse and neglect. Review of the undated, Abuse Prevention Program policy identified the residents had the right to be free from abuse, neglect, misappropriation, corporal punishment and involuntary seclusion. There were systems in place for prevention including employment background checks, mandated reporter training, which included abuse prevention, identification and reporting. The development of timely and thorough investigation, reporting, ongoing review of abuse incidents, and implementation of changes to prevent future abuse occurrences. The administrator or director of nursing would determine if an allegation/incident met the criteria for reportable incident. The policy lacked guidance for staff oversight or re-training for those who were allowed to work following suspension related to allegations of abuse and neglect.
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** Based on interview, and document review the facility failed to immediately report to the state agency (SA) an allegation of staff to resident physical abuse for 1 of 1 resident (R3) reviewed for allegations of abuse. Findings include: R3's 5/21/20, annual Minimum Data Set (MDS), identified R3 had severe cognitive impairment. He required physical assist of 2 for bed mobility, transfers, personal hygiene, and toileting. R3 was frequently incontinent of bladder and had [DIAGNOSES REDACTED]. Review of the 8/14/20, State Agency (SA) report filed at 2:17 p.m., identified on 8/13/20, nursing assistant (NA)-B picked up a torn up brief and threw it back onto resident who had torn it off and was picking at the pieces. The allegation identified NA-B pushed R3 in chest area and pushed him in his wheelchair into his room and closed the door. NA-B had been suspended pending the investigation. Interview on 8/19/20 at 10:48 a.m., with nursing assistant (NA)-A identified the incident with NA-B and R3 happened after lunch on 8/13/20. She did not report it right away as she had made a complaint against NA-B before for yelling at her and nothing happened. She identified that NA-B once told her that she could yell at anyone there and they would not fire her. NA-A was fearful of retaliation from NA-B. The next morning however, she realized she had to report this to someone so she told the social worker as soon as she arrived on 8/14/20. Interview on 8/19/20 at

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

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.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 11:03 a.m., with social worker designee (SW) identified the incident was reported to her on 8/14/20 at 8:10 a.m. NA-A reported witnessing NA-B throw shredded pieces of incontinent product on R3 and push on R3's chest forcefully place R3 in his room and shut the door. NA-A also witnessed and reported NA-B held R3's arms on his chest. NA-A identified an activity aide (AA)-A also witnessed this. SW identified after she was told this information she reported the allegation to the administrator and was instructed to immediately suspend NA-B and start an investigation. The SW identified she had reported the allegation to the administrator, SA, and ombudsman on the same day it was reported to her. The family was not updated because she wanted to finish interviews first. The SW identified the process for reporting staff to resident abuse was to be reported within 24 hours. The facility had 5 days after submitting the alleged abuse to complete and report their investigation findings. Interview on 8/19/20 at 3:05 p.m., with activity aid (AA)-A identified she witnessed NA-B pick up brief pieces and throw it in R3's lap. R3 became upset and threw it back towards NA-B. AA-A identified she was unsure if the charge nurse was notified about the incident, and she had not reported it to anyone. Interview on 8/19/20 at 3:44 p.m., with director of nursing (DON) identified she had been on vacation when incident occurred but had read the information. NA-A might not have reported the allegation immediately because she could of been afraid of retaliation. The DON had received concerns of fear of retaliation from other staff in the past regarding reporting concerns. Staff education included the facility would not tolerate retaliation if allegations of abuse were reported. Interview on 8/21/20 at 8:50 a.m., with SW identified she could not answer why she did not report the abuse allegation to the SA until the afternoon on the day she received the allegation. Interview on 8/21/20 at 9:00 a.m., with the DON identified she expected staff to report any witnessed or suspected abuse immediately to their supervisor. Supervisors were expected to report immediately to the DON or the administrator. The DON, administrator, social service designee, and facility consultant review allegations and determine if the allegation is reportable. If there is harm, the facility reports an abuse allegation within two hours, otherwise without injury, allegations were reported within twenty-four hours. Review of the undated, Abuse Prevention Plan identified the the administrator or director of nursing shall decide if the allegation/incident meet the criteria for reportable incidents. All deemed reportable incidents will be reported via the on-line reporting System within the two hour period. The policy did not include guidance or criteria for reportable incidents for facility staff to follow.