

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

October 7, 2019

Administrator Valley View Estates 1104 4th Avenue Northeast Long Prairie, MN 56347

Re: Project Number SL20675014

Dear Administrator:

On September 23, 2019, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on March 7, 2019; and follow-up survey completed on July 17, 2019. At this time these correction orders were found corrected and are listed on the attached State Form: *Revisit Report.*

If you have questions, contact Jeri Cummins at (218) 302-6193.

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

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Health Regulation Division

Home Care & Assisted Living Program



cc: Cheryl Hennen, Office of the Ombudsman for Long Term Care

Todd County Social Services

			ТАТР	E FORM: REVI	ISIT E	PEDORT				
IDENTIFIC	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building				NLF OK I				OF REVISIT
H20675	<u> </u>	B. Wing						Y2	9/23/2	019 _{Y3}
	FACILITY					TADDRESS, C		ZIP CODE		
VALLEY	VIEW ESTATES					'H AVENUE NO PRAIRIE, MN 5				
	ort is completed by a									
	e action was accomp ition prefix code previ									
ITEI	M	DATE	ITEM	l		DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	00560	Correction	ID Prefix	00865		Correction	ID Prefix	01000		Correction
Reg. #	144A.474, Subd. 8	Completed	Reg. #	144A.4791, Subd. 9	9(a-e)	Completed	Reg.#	144A.4792, Subo	d. 20	Completed
LSC		09/23/2019	LSC			09/23/2019	LSC	-		09/23/2019
ID Prefix	01035	Correction	ID Prefix	01045		Correction	ID Prefix			Correction
Reg. #	144A.4793, Subd. 3	Completed	Reg. #	144A.4793, Subd. 5	5	Completed	Reg.#			Completed
LSC		09/23/2019	LSC			09/23/2019	LSC			=
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg.#			Completed	Reg.#			Completed

LSC

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 20, 2019

Administrator Valley View Estates 1104 4th Avenue Northeast Long Prairie, MN 56347

RE: Project Number SL20675014

DOCUMENTATION OF ACTION TO COMPLY REQUESTED

Dear Administrator:

On July 17, 2019, the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on May 9, 2019. The follow-up survey determined your agency had not corrected all of the state licensing orders issued pursuant to the survey.

In accordance with Minn. Stat. § 144A.474, subd. 11, state licensing orders issued pursuant to the last survey completed on May 9, 2019, found not corrected at the time of the July 17, 2019 follow-up survey and subject to penalty assessment are as follows:

0560-Correction Orders, Minn. Stat. § 144A.474, subd. 8 - \$500.00 1000-Prescription Drugs, Minn. Stat. § 144A.4792, subd. 20 - \$100.00 1035-Individualized Treatment/therapy Mgt Plan, Minn. Stat. § 144A.4793, subd. 3 - \$300.00 1045-Documentation Of Treatment/therapy, Minn. Stat. § 144A.4793, subd. 5 - \$100.00

The details of the violations noted at the time of this revisit completed on July 17, 2019 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is \$1,000.00**. You will be invoiced within 15 days of the receipt of this notice.

DOCUMENTATION OF ACTION TO COMPLY REQUESTED

In accordance with Minn. Stat. § 144A.474, subd. 8(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. At this time, the commissioner requests copies of your documentation and your responsive actions taken to correct the orders issued. Please email this documentation within seven (7) days of your receipt of these orders to Jeri Cummins, Health Resource Supervisor at jeri.cummins@state.mn.us.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;

Valley View Estates August 20, 2019 Page 2

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. You are required to send your written request to the following:

Renae Dressel, Health Program Rep. Sr. Home Care Assisted Living Program Minnesota Department of Health P.O. Box 3879 85 East Seventh Place St. Paul, MN 55101

We urge you to review these orders carefully. If you have questions, please contact Jeri Cummins at 218-302-6193. Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

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Health Regulation Division

Home Care & Assisted Living Program

cc: Cheryl Hennen, Office of the Ombudsman for Long Term Care

Todd County Social Services

			STAT	E FORM: REVI	SIT REPORT					
	ER / SUPPLIER / CLIA /	MULTIPLE CON	ISTRUCTIO	N				DATE	OF REVIS	IT
H20675	CATION NUMBER Y1	A. Building B. Wing					Y2	7/17/2	2019	Y3
NAME O	FACILITY			S	TREET ADDRESS, (CITY, STATE,	ZIP CODE			
WEEL VIEW LOW WE				104 4TH AVENUE NO	DRTHEAST					
	LONG PRAIRIE, MN 56347									
identification form).	ation prefix code previo				ed using either the c codes shown to the					
	ation prefix code previo			urvey Report (prefi						
form).	ation prefix code previo	ously shown on t	the State S	urvey Report (prefi	codes shown to the	ne left of ea			survey rep	
form). ITE Y4	ation prefix code previo	DATE	the State S	urvey Report (prefi	c codes shown to the	ne left of ea	ch requiremen		DATE	port
form). ITE Y4 ID Prefix	ation prefix code previo	DATE Y5 Correction	ITEM Y4 ID Prefix	urvey Report (prefi	DATE Y5 Correction	ITEM Y4 ID Prefix	ch requiremen	t on the s	DATE Y5 Correct	tion
form). ITE Y4 ID Prefix	M 00870	DATE Y5 Correction Completed	ITEM Y4	urvey Report (prefi	DATE Y5 Correction Completed	ITEM	ch requiremen	t on the s	DATE Y5 Correct Comple	tion
form).	M 00870	DATE Y5 Correction	ITEM Y4 ID Prefix	urvey Report (prefi	DATE Y5 Correction	ITEM Y4 ID Prefix	ch requiremen	t on the s	DATE Y5 Correct	tion

144A.4793, Subd. 6

Reg.#

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LSC

Completed

Correction

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Correction

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07/17/2019

Correction

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Reg. #

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144A.4793, Subd. 2

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PRINTED: 08/20/2019 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		H20675	B. WING		07/17/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN &		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE COMPLETE
{0 000}	Initial Comments		{0 000}		
	In accordance with 144A.43 to 144A.43 to 144A.43 been issued pursual Determination of what corrected requires a requirements provide indicated below. Who contains several ite of the items will be compliance. INITIAL COMMENT Project #SL206750 On July 17, 2019, a staff conducted a refollow-up on orders completed on Marcompleted on May	VIDER LICENSING DER Minnesota Statutes, section 32, this correction order(s) has ant to a survey. hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute rms, failure to comply with any considered lack of		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota State Statutes for Home Providers. The assigned tag numappears in the far left column entire Prefix Tag." The state Statute number the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficient column. This column also includes findings which are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the survindings is the Time Period for Complease DISREGARD THE HEAL OF THE FOURTH COLUMN WHI STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TOURS	oftware. to e Care ber tled "ID ber and e Statute ies" s the ne state This as eyors' rrection. DING CH F TO THIS
	comprehensive ser	vices. As a result of the g orders were reissued.		VIOLATIONS OF MINNESOTA STATUTES. THE LETTER IN THE LEFT COLUSED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144A.47 SUBDIVISION 11 (b)(1)(2)	JMN IS SES AND SVEL
{0 560} SS=F	144A.474, Subd. 8	Correction Orders	{0 560}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, DOILDIIVO.		F	₹
		H20675	B. WING			7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 560}	by: Based on observation review, the licensed documentation with the corrections order on March 7, 2019, and on May 9, 2019, with This practice results violation that did not safety but had the public client's health or sa cause serious injury was issued at a wide problems are pervertailure that has affer a large portion or all include: During the revisit ending the survey completed of A review of the licentemployee records, during the survey, but that the licensee has issued on May 9, 20 On July 17, 2019, and employee A verified	ent is not met as evidenced ion, interview and record e failed to have sufficient a actions taken to comply with ers from a survey completed and a revisit survey completed th records reviewed. ed in a level two violation (a th harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect all of the clients). The findings intrance conference on July timately 9:30 a.m. employee A fregistered frator) reported steps had been a issues from the previous on May 9, 2019. Insee's client records, and policies and procedures acked evidence to indicate ad corrected all of the orders one. It approximately 3:30 p.m. It all corrections had not been as issued on May 9, 2019.	{0 560}	DEFICIENCY		
{0 865} SS=C	Implementation & F	9(a-e) Service Plan, Revisions an, implementation, and	{0 865}			

Minnesota Department of Health

STATE FORM 6899 11A913 If continuation sheet 2 of 14

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		H20675	B. WING		F 07/4	
		H20675	B. WING		07/1	7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES	1104 4TH	AVENUE NO	PRTHEAST		
VALLE	VILW LOTATES	LONG PR	AIRIE, MN 5	66347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 865}	Continued From pa	ge 2	{0 865}			
	days after the initiation o provider shall finaliz plan.	plan. (a) No later than 14 f services, a home care ze a current written service				
	include a signature home	or other authentication by the				
	representative docuservices to be provided. The servineeded, based on ounder subdivisions 7 and information to the oprovider's	y the client or the client's umenting agreement on the ce plan must be revised, if client review or reassessment 8. The provider must provide lient about changes to the how to contact the Office of r Long-Term Care.				
		provider must implement and required by the current				
	must be entered int	n and revised service plan to the client's record, including in a client's fees when				
		nome care services must be rent written service plan.				
	by:	ent is not met as evidenced and record review, the				

Minnesota Department of Health STATE FORM

11A913 If continuation sheet 3 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		'	,
		H20675	B. WING		07/1	7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 865}	revisions included a authentication by the client or the clied documenting agree provided for three of #13) with records refered to will also with the client of the complete schemonitoring reviews was present on page documents. The si signatures were on the clients will be signatured as the client will be signatured as the client will be signatured.	nsure that service plan a signature or other he home care provider and by ent's representative ement on the services to be of seven clients (#5, #10 and eviewed. ed in a level one violation (a potential to cause more than in the client and does not affect and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of indings include: to have the clients or s authenticate changed o update service plans when I #13's service plans, dated in 19, 2019, and March 9, had changes made since the 9, 2019, but didn't have a new	{0 865}			
	, , , .	, r - 2000, co - 0000,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		07/1	₹ 7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 865}	employee A (directonurse/RN/administrationur	or of nursing/registered rator) stated "If there is no new ruse I just made the change to attached it to the old service wing them with the clients and so for all the service plans that required information". The provided in the service plans that required information and Revision are provided in the suitable and up-to-date, and seed on the individual preferences." The provided in the individual preferences or changes in the provided in the individual preferences. The provided in the pro	{0 865}			
{01000} SS=F		20 Prescription Drugs	{01000}			
	prior to being set up administration, mus container in which i pharmacy bearing t with legible informa beyond-use date of	-				
	I nis IVIN Requireme	ent is not met as evidenced				

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PRINTED: 08/20/2019 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING		F	
		H20675	B. WING		07/1	7/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01000}	failed to date a time date it was opened receiving medication reviewed. This practice result violation that did not safety but had the policient's health or sa cause serious injury was issued at an is limited number of colimited number of situation has occurre findings include: On July 17, 2019, a storage of medication the assisted living employee F (license Client #13's medications and the afternoon and escond cupboard cont medications and the the afternoon and escond cupboard helantoprost eye drop the date it was ope expire. Manufacturer's recommodity and proximately 2: of nursing/registered.	ion and interview, the licensee esensitive medication with the for one of one client (#13) in services with records ed in a level two violation (a of tharm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and colated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The at approximately 1:30 p.m., the ons managed by the licensee g was observed with ed practical nurse/LPN). ations were stored in her parate locked cupboards.	{01000}			

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Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S	
			A. BUILDING:		R	
		H20675	B. WING			7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
{01000}	would expire. Emp unaware of the need drops when opened had not been dating medications with the	te it was opened or the date it cloyee A reported she was and to date the lantoprost eyed, and verified the licensee grany time sensitive e date they were opened or dexpire and did not have a aff to do so.	{01000}			
{01035} SS=E	management plan. management of orc or therapy services care provider must service plan a writte or therapy services client. The provider maintain a current i therapy management which must contain (1) a statement of t provided; (2) documentation of relating to the treat administration; (3) identification of that will be delegate (4) procedures for r appropriate license	zed treatment or therapy For each client receiving dered or prescribed treatments , the comprehensive home prepare and include in the en statement of the treatment that will be provided to the must also develop and individualized treatment and ent record for each client at least the following: the type of services that will be of specific client instructions	{01035}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		R 07/17	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO			
			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	Continued From pa	ge 7	{01035}			
	services; and					
	documentation of tr received, verification therapy was adminish monitoring of treatments or therapy be current and update changes. This MN Requirements by: Based on interview licensee failed to desindividualized treatments.	d for four of six clients (#2, #5,				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a pat limited number of c a limited number of situation has occur found to be pervasi Records for clients evidence individual management plans all the treatments a receiving, identifica therapy tasks that y unlicensed personn	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than staff are involved, or the red repeatedly; but is not ve). The findings include: #2, #5, #10 and #13 lacked ized treatment and therapy were developed that included not therapies the clients were tion of the treatment or vould be delegated to nel, procedures for notifying a appropriate licensed health				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		67/1	? 7/2019
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0.71	
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01035}	Continued From pa	ge 8	{01035}			
	treatments or thera all treatment and the prescribed, and motherapy to prevent adverse reactions. CLIENT #2	a problem arises with py services, verification that erapy was administered as initoring of treatment or possible complications or es included osteoarthritis,				
	history of urinary tra	act infections, and gout (a sed by excess uric acid in the				
	2019, for ace wrap	criber's orders, dated April 2, (an elastic bandage used to and protect joints) to knee				
		ment and therapy to include any client-specific ng to documentation of				
	condition in which t	noses that included ongestive heart failure (CHF-a he heart's function as a pump eet the body's needs).				
	2019, for oxygen to device used to delive through a lightweig splits into two promostrils and from woxygen flow). Other same date included	criber's orders, dated April 1, vo liters per nasal cannula (a ver oxygen to a patient ht tube which on one end gs that are placed in the hich a mixture of air and er signed orders dated the I, the use of Thick-It in all valk) two times each day, and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		F	,
		H20675	B. WING			7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	AIRIE, MN 5	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
{01035}	Continued From pa	ge 9	{01035}			
	swallow exercises t	twice each day.				
	requirements relating treatment and therefore exercises and Thick lacked any information or the need to ambiday. CLIENT #10 Client #10 had diagrostatic hypertrople and dementia. Client #10 had prese 2019, that included					
	individualized treati management plan t	to include any client-specific ng to documentation of				
		noses that included positional lood pressure) and diabetes				
	2018, that included	deterrent hose (used in the				
	Client #13's record	lacked a developed				

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Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		67/1	R 7/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		.,
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	individualized treatr management plan to thromboembolism-or on July 17, 2019, a employee A (direct nurse/RN/administr clients #2 and #10 and therapy management plan that included a Employee A reporter medication and not verified the medication and not verified records for contain the oxygen.	ment and therapy to include the deterrent hose. It approximately 12:00 p.m., or of nursing/registered rator) verified records for did not contain a treatment tement plan that included all it. Later the same day, at 0 p.m., employee A also clients #5 and #13 did not and therapy management all the required content. ed she thought oxygen was a a treatment or therapy, but tion management plan didn't either. by "Delegation of Nursing or Therapy Tasks" dated ted: or therapy is delegated or sed personnel, the RN or d Health Professional must: intain a current individualized y management record for liresses the requirements of	{01035}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		F	.	
		H20675	B. WING			7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{01035}	Continued From pa	ge 11	{01035}				
	specific procedures for treatments and therapy management services that staff will provide."						
	No further information was provided.						
{01045} SS=D	144A.4793, Subd. 5 Documentation of Treatment/Therapy		{01045}				
	Subd. 5. Documentation of administration of treatments and therapies. Eachtreatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs.						
	by: Based on interview licensee failed to a (compression stock the reason why it we follow-up procedure)	and record review, the dminister a treatment sings) and did not document as not administered and any es that were provided to meet or one of six clients (#13) with					
	violation that did no safety but had the p client's health or sa cause serious injur was issued at an is	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					F	3
		H20675	B. WING		07/1	7/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01045}	Continued From pa	ge 12	{01045}			
		taff are involved or the red only occasionally). The				
	treatments and ther prescribed, and did the reason why the	t #13 lacked evidence rapies were administered as not include documentation of y were not administered, and edures that were provided to eds.				
		noses that included positional ood pressure) and diabetes				
		scriber's orders dated July 11, knee high compression				
		lacked documentation of the e compression stockings.				
	employee F reporte compression stocki worn them prior to t	It approximately 1:30 p.m., ed client #13 hadn't worn her ngs for about a week, but had that. Employee F didn't recall he assistance with the ngs.				
	client #5 reported s	nt approximately 1:45 p.m., he wore the compression ally and sometimes needed em on.				
	nurse/RN/administr client #13 ever word and indicated the a	or of nursing/registered rator) reported she didn't think her compression stockings dministration of treatments ted on the "Service Recap				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:		_	,
		H20675	B. WING		07/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEW ESTATES			AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	compression stocki documented as pro noted on the service Residex (computer The "Service Recardocumentation that assistance with the June or July, 2019. The licensee's police Therapy Services "The Home Care Dwhich treatment or will offer, which maia. Staff that will peid. RN (documentation. LPN (Documentation. Physical Therapy provide documentativ. Other Licensed states.)	yee A also verified the ings were not being vided, because they weren't e plan or anywhere else in software program). De Summary" lacked a reflected staff had provided compression stockings in the compression stockings	{01045}			

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Email: MARYDVORAK6@GMAIL.COM

June 5, 2019

Ms. Mary Dvorak, Administrator Valley View Estates 1104 4th Avenue Northeast Long Prairie, MN 56347

Re: Enclosed State Licensing Orders - Project Number SL20675014

Dear Ms. Dvorak:

On May 9, 2019, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on March 7, 2019.

State licensing orders issued pursuant to the survey completed on March 7, 2019, found corrected at the time of the May 9, 2019 follow-up survey, are listed on the attached State Form: *Revisit Report*.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

IMPOSITION OF FINES

Level 1, no fines or enforcement.

Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations.

Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

At the time of this survey it was determined, in accordance with Minn. Stat. 144A.474, subd. 11, the following fines were issued:

\$100.00	Level/2; Scope/Isolated Service Plan, Implementation & Revisions, Minn. Stat. 144A.4791, subd. 9 (a-e)
NO FINE	Level/1; Scope/Widespread Contents Of Service Plan, Minn. Stat. 144A.4791, subd. 9 (f)
\$100.00	Level/2; Scope/Isolated Individualized Medication Monitoring/reassess, Minn. Stat. 144A.4792, subd. 3
\$100.00	Level/2; Scope/Isolated Individualized Medication Mgt Plan, Minn. Stat. 144A.4792, subd. 5
\$100.00	Level/2; Scope/Isolated Prescription Drugs, Minn. Stat. 144A.4792, subd. 20
\$500.00	Level/2; Scope/Widespread Policies And Procedures, Minn. Stat. 144A.4793, subd. 2
\$500.00	Level/2; Scope/Widespread Individualized Treatment/therapy Mgt Plan, Minn. Stat. 144A.4793, subd. 3
\$100.00	Level/2; Scope/Isolated Documentation Of Treatment/therapy, Minn. Stat. 144A.4793, subd. 5
\$100.00	Level/2; Scope/Isolated Orders Or Prescriptions, Minn. Stat. 144A.4793, subd. 6

Total = **\$1,600.00**

The details of the violations noted at the time of this follow-up survey completed on April 9, 2019, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stats. 144A.43 to 144A.484, the total amount that you are assessed is \$1,600.00. An invoice will follow with information on how to submit your payment. Interest will be charged if fines are not paid by the invoiced due date.

In accordance with Minn. Stat. 144A.475, subd. 4, you may request a hearing on any fines resulting from noncompliance with these orders provided that a written request is made to the Department within 15 calendar days of receipt of this notice.

Also, at the time of this follow-up survey completed on May 9, 2019, additional violations were cited as follows:

Valley View Estates June 5, 2019 Page 3

> Level/2; Scope/Widespread Correction Orders, Minn. Stat. 144A.474, subd. 8

They are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders.

If, upon follow-up, MDH finds that the correction order(s) cited herein is/are not corrected, MDH will assess fine for each order not corrected in accordance with a schedule of fines described in Minn. Minn. Stat. 144A.474, subd. 11.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed. The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date. The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health.Homecare@state.mn.us; or, if you prefer you can mail it to:

Home Care Correction Order Reconsideration Process
Minnesota Department of Health/Health Regulation Division
P.O. Box 3879
85 East 7th Place, Suite 220
St. Paul, Minnesota 55101

NOTE: Do not send payments for fines to this address. Payments should be mailed to the address listed on the invoice that will be emailed to your company. **If you have any questions about the invoice when you receive it, contact MDH Finance at 651-201-3544.** This same number is listed directly on the invoice.

We urge you to review these orders carefully. If you have questions regarding the written orders, contact Jeri Cummins at (218) 302-6193.

It is your responsibility to share the information contained in this letter and the results of the visit

Valley View Estates June 5, 2019 Page 4

with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

faula Mastran

Health Regulation Division

Home Care & Assisted Living Program













Enclosure

Cheryl Hennen, Office of the Ombudsman for Long Term Care cc:

Todd County Social Services

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
H20675 _{Y1}	B. Wing		Y2	5/9/2019	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
VALLEY VIEW ESTATES		1104 4TH AVENUE NORTHEAST			
		LONG PRAIRIE, MN 56347			

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	00265		Correction	ID Prefix	00790		Correction	ID Prefix	00805		Correction
Reg. #	144A.44, Subd.	1(2)	Completed	Reg. #	144A.4	79, Subd. 3	 Completed	Reg.#	144A.479, Subd.	6(a)	Completed
LSC			05/09/2019	LSC			05/09/2019	LSC			05/09/2019
ID Prefix	00815		Correction	ID Prefix	00835		Correction	ID Prefix	00860		Correction
Reg. #	144A.479, Subd	. 7	Completed	Reg. #	144A.4	791, Subd. 3	Completed	Reg.#	144A.4791, Subo	d. 8	Completed
LSC			05/09/2019	LSC			05/09/2019	LSC			05/09/2019
ID Prefix	00905		Correction	ID Prefix	00940		Correction	ID Prefix	00950		Correction
	144A.4792, Sub	d. 2	Completed	Reg. #		792, Subd. 9	Completed	Reg. #	144A.4792, Subo	d. 10(b)	Completed
LSC			05/09/2019	LSC			05/09/2019	LSC			05/09/2019
ID Deefee	04040		O a maratia m	ID Desfer	0.4.0.0.0		0	ID Desfer	04455		0
ID Prefix		d 1	Correction	ID Prefix			Correction	ID Prefix		4 7/4)	Correction
Reg. #	144A.4793, Sub	u. 4	Completed	Reg. #	144/1.4	794, Subd. 3	Completed	Reg. #	144A.4795, Subo	u. 7(u)	Completed
LSC			05/09/2019	LSC			05/09/2019	LSC			05/09/2019
ID Prefix	01170		Correction	ID Prefix	01190		Correction	ID Prefix	01225		Correction
Reg. #	144A.4796, Sub	d. 2	Completed	Reg. #	144A.4	796, Subd. 6	Completed	Reg.#	144A.4797, Subo	d. 3	Completed
LSC			05/09/2019	LSC			05/09/2019	LSC			05/09/2019
REVIEWE STATE AC		REVIEW (INITIAL		DATE		SIGNATURE O	F SURVEYOR	I		DATE	
REVIEWE	ED BY	REVIEW (INITIAL		DATE		TITLE				DATE	

Page 1 of 2 EVENT ID: 11A912

			STAT	E FORM: RE	VISIT REPORT				
PROVIDER / SUPPLIER IDENTIFICATION NUMBER H20675		MULTIPLE CON A. Building B. Wing	STRUCTIO	N				DATE OF RE\	
NAME OF FACILITY VALLEY VIEW ESTATI					STREET ADDRESS 1104 4TH AVENUE LONG PRAIRIE, MI		Y2 ODE		Y3
This report is complete corrective action was a identification prefix cod form).	ccomplis	shed. Each defi	ciency sho	uld be fully ident	tified using either th	e regulation or LSC	provision	number and t	
ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DAT Ys	
D Prefix 01245		Correction	ID Prefix	02025	Correction	1			
Reg. # 144A.4798, Sul	bd. 1	Completed 05/09/2019	Reg. # LSC	626.557, Subd. 4	Completed 05/09/2019				
_SC		-	LSC		03/03/2019	+			
REVIEWED BY STATE AGENCY: MDH		WED BY LS): PMB	DATE: 6/	5/19 SIGNATI	JRE OF SURVEYOR	: 34170		DATE: 5/9/19	
REVIEWED BY CMS RO	REVIEN (INITIA	WED BY LS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVE 3/7/2019	Y COMPL	ETED ON				IENCIES. WAS A SUM 37) SENT TO THE FAC		☐ YES ☐] NO
			-	Page 2 c	f 2	E\/EN	NT ID:	11 / 012	

Page 2 of 2 EVENT ID: 11A912

PRINTED: 06/05/2019 FORM APPROVED

Minnesota Department of Health

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
					R	
		H20675	B. WING		05/09/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NC AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETE	
{0 000}	000) Initial Comments					
	In accordance with 144A.43 to 144A.45 been issued pursual Determination of what corrected requires a requirements provide indicated below. With the corrected requirements provide indicated below.	VIDER LICENSING DER Minnesota Statutes, section 32, this correction order(s) has ant to a survey. hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute ems, failure to comply with any		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far left column entity Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Control of the statement of the survey findings is the Time Period for Control of the statement of the survey findings is the Time Period for Control of the statement of the survey findings is the Time Period for Control of the statement of the survey findings is the Time Period for Control of the statement o	oftware. to e Care ber tled "ID ber and e Statute ies" s the ne state This as eyors'	
	INITIAL COMMENTS: Project #SL20675014 On May 8 and 9, 2019, a surveyor of this Department's staff conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 7, 2019. At the time of the survey, there were 27 clients that were receiving services. As a result of the revisit, the following orders were reissued, and one new order was issued.			PLEASE DISREGARD THE HEAD OF THE FOURTH COLUMN WHI STATES,"PROVIDER 'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATUTES. THE LETTER IN THE LEFT COLUMNED FOR TRACKING PURPOST REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144A.47 SUBDIVISION 11 (b)(1)(2)	CH F TO THIS O THIS O TATE JMN IS SES AND EVEL	
0 560 SS=F	144A.474, Subd. 8	Correction Orders	0 560			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	
		H20675	B. WING		05/0	9/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	AIRIE, MN 5	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 560	Continued From pa	ge 1	0 560			
	by: Based on observation review, the licensed documentation with the corrections order on March 7, 2019, and the problems are perventional to the problems are pervential to the problems	ent is not met as evidenced ion, interview and record e failed to have sufficient a actions taken to comply with ers from a survey completed with records reviewed. ed in a level two violation (a ot harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect ll of the clients). The findings				
	2019, at approximal (director of nursing nurse/RN/administrate taken to correct the survey completed of the lice employee records, during the survey, I that the licensee has issued on March 7, On May 9, 2019, at employee A verified made for the orders.	rator) reported steps had been issues from the previous on March 7, 2019. Insee's client records, and policies and procedures acked evidence to indicate ad corrected all of the orders 2019. Insee's client records, and procedures acked evidence to indicate ad corrected all of the orders 2019. Insee's client records, and procedures acked evidence to indicate ad corrected all of the orders 2019.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		F	,
		H20675	B. WING			9/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
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	(21) days					
{0 865} SS=D	144A.4791, Subd. 9 Implementation & F		{0 865}			
	revisions to service days after the initiation o	an, implementation, and plan. (a) No later than 14 f services, a home care ze a current written service				
	include a signature home care provider and be representative docuservices to be provided. The servineeded, based on ounder subdivisions 7 and information to the oprovider's fee for services and the Ombudsman for (c) The home care	provider must implement and				
		required by the current				
	must be entered int	n and revised service plan to the client's record, including in a client's fees when				
		nome care services must be				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	
			A. BOILDING.		R	,
		H20675	B. WING			9/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
0/A) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	AIRIE, MN 5			(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	.D BE	(X5) COMPLETE DATE
{0 865}	Continued From pa	ge 3	{0 865}			
	This MN Requirements: Based on interview licensee did not prothe service plan (mitted service plan (mitted service plan (mitted service plan (mitted service result violation that did not safety but had the polient's health or sacause serious injury was issued at an is limited number of colimited number of situation has occurrifindings include: The licensee failed indicated on the second colimited number of situation has occurrifindings include: The licensee failed indicated on the second colimited number of situation has occurrifindings include: The licensee failed indicated on the second colimited number of situation has occurrifindings include: The licensee failed indicated on the second colimited number of situation administration administ	and record review, the ovide all services as noted on edication set up) for one of a records reviewed. ed in a level two violation (a ot harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and colated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		H20675	B. WING			R 09/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
{0 865}	Plan", that also indiassistance by the Fweekly and as need On May 8, 2019, at employee A (directonurse/RN/administr does not set-up metime, and the medic the client's service The licensee's polic of the Service Plant noted: "All home care service accordance with a swritten service plant client's needs and purification in the client's needs, plant the client's needs and date and/or the client's revised service	cated client #4 received RN with medication set-up ded. approximately 4:30 p.m., or of nursing/registered rator) reported the licensee dications for client #4 at this cation set-up should not be on plan. by "Development and Revision" dated March 27, 2019, vices are provided in suitable and up-to-date, based on the individual preferences." ervice plan indicates that the needs modification based on preferences, or changes in pist and/or other licensed (as applicable) makes to the service plan with e, and requests that the client epresentative sign and date plan."	{0 865}			
{0 870} SS=C	No further informati	9(f) Contents of Service Plan	{0 870}			
	(f) The service plan	must include:				
	provided, the fees f frequency of each service, accor	the home care services to be for services, and the rding to the client's current ent and client preferences;				

Minnesota Department of Health

STATE FORM 6899 11A912 If continuation sheet 5 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA) DATE SURVEY COMPLETED	
					R		
		H20675	B. WING			9/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO RAIRIE, MN 5				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
{0 870}	Continued From pa	ge 5	{0 870}				
	(2) the identification staff who will provide	n of the staff or categories of le the services;					
	(3) the schedule ar reviews or assessn	nd methods of monitoring nents of the client;					
		f sessions of supervision of rsonnel who will supervise					
	provider and by the representative if the scheduled service (ii) information and client's representat provider; (iii) names and con the client wishes to emergency or if there is a significa client's condition, ir information as to who has auth emergency; and (iv) the circumstant medical services at consistent with	taken by the home care e client or client's e cannot be provided; a method for a client or live to contact the home care tact information of persons have notified in an ant adverse change in the including identification of and cority to sign for the client in an less in which emergency re not to be summoned.					
	by: Based on interview licensee failed to in	and record review the clude the required contents in six of six clients (#2, #4, #5)					

Minnesota Department of Health STATE FORM

ATE FORM 11A912 If continuation sheet 6 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
			71. BOILBING.		F		
		H20675	B. WING			9/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO				
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	AIRIE, MN (PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
{0 870}	Continued From pa	ge 6	{0 870}				
	#10, #11 and #12) records reviewed.	receiving services with					
	This practice results violation that has not a minimal impact or health or safety), a widespread scope or represent a system or has potential to a the clients). The first Service plans for clients and diagram of limited to, ostem tract infections (UT) caused by excess to Client #2's service plans for client #2's service plans for climited to, ostem tract infections (UT) caused by excess to Client #2's service plans for client plants and plants for client pla	(when problems are pervasive emic failure that has affected affect a large portion or all of a large portion of a large portio					
	2018, noted service	plan, dated December 12, es that included medication st of one staff with all ADL's					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY COMPLETED	
					R		
		H20675	B. WING		05/0	9/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{0 870}	Continued From pa	ge 7	{0 870}				
	(activities of daily living), and "Medication Set up by RN weekly and PRN" [as needed]. The client's service plan lacked the methods of monitoring reviews or assessments of the client.						
	(high blood pressur failure (CHF-a cond	oses to include hypertension e) and congestive heart lition in which the heart's is inadequate to meet the					
	Client #5's service plan, dated April 3, 2019, noted services that included medication administration, assist with all ADL's, oxygen assistance, and medication setup. The client's service plan lacked the complete schedule and methods of monitoring reviews or assessments of the client.						
		noses to include benign ny (BPH) with urinary retention					
	noted services that with all ADL's (activ client's service plan	e plan, dated March 19, 2019, included assist of one staff ities of daily living). The lacked the methods of or assessments of the client.					
	CLIENT #11 Client #11 had diag and diabetes mellite	noses to include dementia us.					
	noted services that with all ADL's (activ	plan, dated March 19, 2019, included assist of one staff ities of daily living). The lacked a description of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	JILDING:		
		H20675	B. WING		05/0	₹ 9/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
0(4) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	· ·		ON	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{0 870}	Continued From pa	ge 8	{0 870}			
	home care services to be provided (diabetic diet) and the methods of monitoring reviews or assessments of the client.					
	CLIENT #12 Client #12 had diagnoses to include polymyalgia rhuematica (an inflammatory disorder that causes muscle pain and stiffness, especially in the shoulders).					
	Client #12's service plan, dated April 25, 2019, noted services that included assistance with medication administation and medication set-up by a registered nurse/RN. The client's service plan lacked the methods of monitoring reviews or assessments of the client.					
	On May 8, 2019, at approximately 2:15 p.m., employee A (director of nursing, registered nurse/RN, administrator) verified all the required content was not included in service plans for clients #2, #4, #5, #10, #11 and #12 and stated "I'm sure all of our clients are missing the methods of monitoring reviews or assessments of the client."					
	Plans", dated Marc plan established af individualized initial subsequent reasse a. A description of t including nursing a services, treatment be provided by our "f. The schedule an reviews or re-asses	he home care services, and medication management is and or therapy services, to agency." If methods of monitoring is sements of the client."				
	No further informat	on was provided.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
					F		
		H20675	B. WING		05/0	9/2019	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE	
	144A.4792, Subd. 3 Monitoring/Reasses Subd. 3. Individuali and reassessment. care provider must moni medication manage under subdivision 2 when symptoms or other medication-related This MN Requireme by: Based on interview licensee failed to de individualized medi was current for the two clients (#4) with This practice result violation that did no safety but had the p client's health or sa cause serious injury was issued at an is limited number of c limited number of s situation has occurr findings include: Client #4's record la monitored and reas management service	Individualized Medication as seed medication monitoring The comprehensive home tor and reassess the client's ement services as needed the client presents with issues that may be and, at a minimum, annually. The cord review, the evelop and maintain an cation management plan that services provided for one of	{0 910}				
		oses that included stroke lood supply to part of the brain					

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STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		R		
		H20675	B. WING			9/2019
NAME OF PROV	IDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEV	N ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
is ir of control of co	ent #4's service part #4's gistered nurse/R part #4's	cluced, depriving brain tissue ents). Dolan, dated December 12, as that included medication st of one staff with all ADL's ving), and "Medication Set up PRN" [as needed]. Client #4's mentation of medication setup summary", by employee BN), dated March 25, 2019, redication management and approximately 4:30 p.m., or of nursing/RN/administrator) es not receive medication rrently. Employee A reported recall when [client #4] stopped a setup, or if she ever did." erified the licensee did not a medication services as a set y "Development of the cation Management Plan and cation Record," dated March as that each client's cation Management Plan is a consistent with prescriber's needs and preferences of the nitor and reassess the client's	{0 910}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		R 05/09/2019	
	PROVIDER OR SUPPLIER	1104 4TH	AVENUE NO			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
{0 910}		·	{0 910}	DEFICIENCY)		
(0 910)	based on the RN's b. When the client	judgement); and presents with symptoms or ay be medication related."	(0 910)			
{0 920} SS=D	144A.4792, Subd. 5 Individualized Medication Mgt Plan		{0 920}			
	plan. (a) For each of management service care provider must service plan a writte medication manage provided to the clien provider must deveindividualized medicach	ement services that will be nt. The lop and maintain a current cation management record for client's assessment that must				
	management service (2) a description of on the client's need diversion, and considerations; (3) documentation of relating to the admit (4) identification of monitoring medication refills are (5) identification of tasks that may be opersonnel; (6) procedures for service of the control of tasks that may be opersonnel;	scribing the medication ces that will be provided; storage of medications based is and preferences, risk of sistent with the manufacturer's of specific client instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management delegated to unlicensed staff notifying a registered e licensed health professional				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED	
			A. BOILDING.		R		
		H20675	B. WING			9/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY V	/IEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
	services; and (7) any client-specific documenting medic verifications that all medications prescribed, and mo prevent possible complications or ad (b) The medication current and update changes. This MN Requiremed by: Based on interview licensee failed to decomplete and accumanagement plant to content (medication (#4) with records retained to the possible complete and accumanagement plant to content (medication (#4) with records retained to the possible complete and accumanagement plant to content (medication (#4) with records retained to the possible complete and accumanagement plant to content (medication (#4) with records retained to the possible complete and accumanagement plant to content (medication (#4) with records resultation that did not safety but had the polient's health or sa cause serious injury was issued at an is limited number of content indings include: Client #4's medications.	ith medication management fic requirements relating to cation administration, are administered as initoring of medication use to liverse reactions. management record must be d when there are any ent is not met as evidenced and record review the evelop and maintain a rate individualized medication that included all the required a set up) for one of two clients eviewed. ed in a level two violation (a tharm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and colated scope (when one or a lients are affected or one or a lients are affected or one or a taff are involved or the red only occasionally). The	{0 920}				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP			SURVEY LETED	
		H20675	B. WING		R 05/09/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 920}	Client #4 had diagn (occurs when the b is interrupted or recoff oxygen and nutrically continued of oxygen and nutrically continued or recoff oxygen and nutrically continued or record administration, assist (activities of daily limby RN weekly and I record lacked docuby the RN. A "Clinical Update of (registered nurse/R noted "Needs full most up." On May 9, 2019, at employee A (director verified client #4 domedication setup by reported that "staff stopped needing morior to the last survey of the last survey of the last survey of the licensee's policinally continued. The licensee's policinally continued of the RN ensures of the RN ens	looses that included stroke lood supply to part of the brain luced, depriving brain tissue ents). plan, dated December 12, es that included medication st of one staff with all ADL's ving), and "Medication Set up PRN" [as needed]. Client #4's mentation of medication setup Summary", by employee B N), dated March 25, 2019, hedication management and approximately 8:30 a.m., or of nursing/RN/administrator) hes not currently receive by the RN. Employee A doesn't recall when [client #4] edication setup, but it was vey [on March 19, 2018]." Perified the licensee did not ion management plan as ication setup was by "Development of the cation Management Plan and cation Record," dated March	{0 920}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		H20675	B. WING			9/2019
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
{0 920}	medication manage a. As needed at the visits (at least every based on the RN's b. When the client	nitor and reassess the client's ement services: enurse's periodic monitoring y 90 days or more frequently judgement); and presents with symptoms or ay be medication related."	{0 920}			
{01000} SS=D	Subd. 20. Prescript prior to being set up administration, must container in which i pharmacy bearing the with legible information beyond-use date of the with the second process of the second process	ent is not met as evidenced on and interview, the licensee beyond-use date of a one of six clients (#6) n services, and failed to ion label information was e expiration or beyond-use	{01000}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		7. Bollbing.		R	
	H20675	B. WING			9/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEW ESTATES		AVENUE NO AIRIE, MN 5			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
storage of medication in the assisted living employee G (register that the following medication of the labels of t	approximately 10:30 a.m., the ons managed by the licensee g was observed with ered nurse/RN). It was noted edications for client #6 had swere illegible: ases blood pressure) 25 mg expiration date that had been marker that noted "9 AM 3:30 in date of the medication was dion medication used to treat e) 20 mg had an expiration is, 2019. 100 a.m., employee A RN/administrator) verified the above were expired, and elacked a process for an dates of the medications 101 my "Medication Administration is Set-Up", dated March 31, and medications, the nurse will in date of the medication and cription needs to be renewed and will follow up with the narmacy if a new prescription by "Storage of Medications",	{01000}			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1100075	B. WING		R 05/09/2019	
NAME OF F	PROVIDER OR SUPPLIER	H20675		STATE, ZIP CODE	05/0	9/2019
	VIEW ESTATES		AVENUE NC	,		
LONG PE			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01000}	Continued From pa	ge 16	{01000}			
	stating the prescrip strength and quanti time-dated drug, dir prescriber's name,					
(0.4000)	· ·		(0.4.0.0.)			
{01030} SS=F		2 Policies and Procedures	{01030}			
	Subd. 2. Policies and procedures. (a) A comprehensive home care provider who provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.					
	address requesting prescriptions for tre providing the treatm of treatment or ther communicating with therapy they are re-	cies and procedures must and receiving orders or satments or therapies, ment or therapy, documenting apy activities, educating and an clients about treatments or ceiving, monitoring and ment and therapy, and in the prescriber.				
	by: Based on interview	and record review the evelop, implement, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		Б	
		H20675	B. WING		05/0	9/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
	management polici included the require treatment or therap communicating with therapy they were reviewed. This practice result violation that did not included includes a second control of the requirement of the requiremen	e written treatment or therapy es and procedures that ed content of documenting of y activities and educating and n clients about treatments or receiving, with records ed in a level two violation (a ot harm a client's health or				
	safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include:					
	A review of the licensee's treatment and therapy management policies revealed that they lacked the required content to address documenting of treatment or therapy activities and educating and communicating with clients about treatments or therapy they were receiving.					
	employee A (director nurse/RN/administration of developed, impourrent written treatmanagement policitincluded document activities and education of the control of the contr	es and procedures that ing of treatment or therapy ating clients and/or the clients' out treatments and therapies				
		·				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		R 05/09/2019	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		0.20.0
VALLEY VIEW ESTATES			AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	Continued From pa	ge 18	{01035}			
{01035} SS=F	144A.4793, Subd. 3 Individualized Treatment/Therapy Mgt Plan		{01035}			
	management plan. management of ord or therapy services care provider must service plan a writte or therapy services client. The provider maintain a current i therapy manageme which must contain (1) a statement of the provided; (2) documentation of relating to the treate administration; (3) identification of that will be delegate (4) procedures for r appropriate license problem arises with services; and (5) any client-specif documentation of tr received, verificatio therapy was admini monitoring of treate possible complicatio treatment or therap	For each client receiving lered or prescribed treatments, the comprehensive home prepare and include in the en statement of the treatment that will be provided to the must also develop and individualized treatment and int record for each client at least the following: The type of services that will be of specific client instructions ments or therapy The treatment or therapy tasks and to unlicensed personnel; The totifying a registered nurse or display the and treatments or therapy The treatment and therapy The treatment and therapy The treatment and therapy The treatment or therapy to prevent one or adverse reactions. The y management record must attend when there are any				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		H20675	B. WING		05/0	9/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY VIEW ESTATES			AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	Continued From page 19		{01035}			
	This MN Requirement by: Based on interview licensee failed to do individualized treatmanagement record #10, #11 and #12). failed to prepare an written statement of services that were lone of six clients (# This practice result violation that did not safety but had the polient's health or sa cause serious injury was issued at a wide problems are pervertailure that has affer a large portion or a include: INDIVIDUALIZED TAMANAGEMENT PLA Records for clients individualized treatmanagement plans the required content procedures for notappropriate license problem arises with services; and any client-specific documentation of treceived, verification therapy was admining the required content of the procedure of the pro	and record review, the evelop and maintain a current ment and therapy d for five of six clients (#2, #5, In addition, the licensee of include in the service plan a f the treatment or therapy being provided to the client for each in a level two violation (a set harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when easive or represent a systemic cted or has potential to affect II of the clients). The findings				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: ((X3) DATE SURVEY COMPLETED	
					R		
		H20675	B. WING		05/0	9/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	COMPLETE DATE	
{01035}	Continued From pa	ge 20	{01035}				
	possible complication	ons or adverse reactions.					
	CLIENT #2 Client #2's diagnoses included osteoarthritis, history of urinary tract infections, and gout (a form of arthritis caused by excess uric acid in the bloodstream).						
	Client #2 had prescriber's orders, dated October 10, 2018, for Ace wrap (an elastic bandage used to decrease swelling and protect joints) to knee PRN (as needed).						
	Client #2's record lacked a developed individualized treatment and therapy management plan to include the required content noted above.						
	CLIENT #5 Client #5 had diagnoses that included hypertension and congestive heart failure (CHF-a condition in which the heart's function as a pump is inadequate to meet the body's needs).						
	2017, for oxygen tw device used to delive through a lightweig splits into two prong	criber's orders, dated June 15, vo liters per nasal cannula (a ver oxygen to a patient ht tube which on one end gs that are placed in the hich a mixture of air and					
	Client #5's record la individualized treati management plan to noted above.						
	CLIENTS #10 and : Clients #10 and #1	#12 2's records lacked evidence					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING	B. WING		≷ 9/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	that an individualize management plan verification that a administered as pretreatment or therap complications or ad CLIENT #10 Client #10 had diag prostatic hypertrophand dementia. Client #10 had pres 2019, that included Client #10's record individualized treatment plan to noted above. CLIENT #12 Client #12 had diag polymyalgia rheums	ed treatment and therapy was developed to include the follows: Il treatment and therapy was escribed, and monitoring of y to prevent possible verse reactions. Inoses that included benign my (BPH) with urinary retention ecriber's orders, dated April 7, "thicken liquids". Ilacked a developed ment and therapy o include the required content enoses that included atica (an inflammatory is muscle pain and stiffness,	{01035}			
		scriber's orders, dated March ded monitoring blood glucose nisone.				
	individualized treatr	lacked a developed ment and therapy o include the required content				
	CLIENT #11 Client #11's record individualized treatr	lacked evidence that an ment and therapy				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		F	,
		H20675	B. WING			9/2019
NAME OF PROVIDE	R OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEW E	STATES		AVENUE NO AIRIE, MN 5			
1 1 1 1 1 1 1 1	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
mana requir - a sta provid - proceappro proble servid - verif admir treatm comple Client and d Client 26, 20 Client individes mana noted On Matemple nurse clients treatm include that it clients record SERV CLIEN Client lacked	ed content as atement of the atement of the led (diabetic of edures for no priate license em arises with es; ication that all istered as propertion or therapications or act #11 had diagraphent or therapications or act #11 had present and the led all the required and theraped and the required and theraped and the required and the required and theraped and the required and the requi	was developed to include the strollows: etype of services that will be diet); diffying a registered nurse or ed health professional when a nate treatments or therapy I treatment and therapy was escribed, and monitoring of by to prevent possible diverse reactions.	{01035}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING			R 09/2019
	PROVIDER OR SUPPLIER	1104 4TH	DRESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{01035}	client. Client #11 was receas ordered by the pplan lacked the serdiabetic diet. On May 9, 2019, at employee A verified lacked a written stathat were provided. The licensee's police Tasks, Treatments March 26, 2019, no "When a treatment assigned to unlicent authorized Licensea. Develop and matreatment or therapeach client that add MN Statutes 144.4. The licensee's police Plans", dated March plan established affindividualized initial subsequent reassea. A description of including nursing at	eiving a modified diabetic diet prescriber. Client #11's service vices for assistance with the approximately 8:30 a.m., If the service plan for client #11 plants the service plan for client #11 plants of all the treatments. By "Delegation of Nursing or Therapy Tasks" dated personnel, the RN or died: or therapy is delegated or used personnel, the RN or died. Health Professional must: intain a current individualized y management record for presses the requirements of the service for the services of the services, and medication management includes: the home care services, and medication management is and or therapy services, to agency."	{01035}			
{01045} SS=D	Treatment/Therapy	5 Documentation of	{01045}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BOILBING.			R	
	H20675	B. WING			09/2019	
NAME OF PROVIDER OR SUPPL	IER STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY VIEW ESTATES		I AVENUE NO RAIRIE, MN {				
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
therapy administered record. The doc signature and the administered the include the date. When treatment administered as provider must control administered that were provider must control administered that were provider must control administered that were provided the records and control administered that were provided the rapies and control administered that were provided the rapies and control administered that were provided the rapies and control administered that administered records reviewed. This practice records reviewed. This practice records reviewed. This practice records reviewed. This practice records reviewed. This practice records reviewed. This practice records reviewed. The records reviewed that the cause serious is was issued at a limited number limited number situation has off findings included. The record for treatments and prescribed, and they were not a signature and the records and they were not a signature and the records and they were not a signature.	therapies. Eachtreatment or stered by a comprehensive home ust be documented in the client's numentation must include the tile of the person who is treatment or therapy and must and time of administration. It or therapies are not cordered or prescribed, the ocument the reason why it was do and any follow-up procedures led to meet the client's needs. The ement is not met as evidenced liew and record review, the condition and any follow-up were provided to meet the or one of three clients (#11) with each. The potential to have harmed a resafety, but was not likely to injury, impairment, or death), and in isolated scope (when one or a of staff are involved or the curred only occasionally). The					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		1100075	B. WING		R 05/09/2019	
		H20675	B. WINO		05/0	9/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01045}	Continued From pa	ge 25	{01045}			
	client's needs.					
	Client #11 had diag and diabetes mellite	noses that included dementia us.				
	Client #11 had pres 26, 2019, that include	criber's orders dated January ded a diabetic diet.				
	Client #11's record administration of a	lacked documentation of the diabetic diet.				
	employee A (directonurse/RN/administration of tre					
		o Summary" lacked reflected staff had provided a the months of April and May				
	employee A verified	approximately 4:30 p.m., I the lack of documentation rided the diabetic diet for client the prescriber.				
		ot provide a policy regarding of treatments and therapies.				
	No further informati	on was provided.				
{01050} SS=D	144A.4793, Subd. 6	6 Orders or Prescriptions	{01050}			
	an up-to-date writte order or prescription therapies. The orde	prescriptions. There must be en or electronically recorded in for all treatments and er must contain the name of otion of the treatment or				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R		
		H20675	B. WING			9/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY VIEW ESTATES			AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
{01050}	Continued From page 26		{01050}				
	therapy to be provided, and the frequency and other information needed to administer the treatment or therapy.						
	by: Based on interview licensee failed to of for the treatments to one of five clients (some of five clients one of five clients one of five clients one of five clients one of five clients of the process of the proce	and record review, the otain accurate prescriptions heir staff was administering for #11) with records reviewed. ed in a level two violation (a ot harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The					
	Client #11 had diag and diabetes mellition. On May 8, 2019, at employee A (directonurse/RN/administrational signed prescriber's testing being provide reported she could for the blood glucos we just do it at mean the licensee's policional control in the licensee's polici	noses that included dementia					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		H20675			05/0	9/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S AVENUE NC	STATE, ZIP CODE		
I VALLEY VIEW ESTATES			AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{01050}	Continued From pa	ge 27	{01050}			
{01050}	dated March 5, 201 "A medication presentherapy order must at least every 12 mindicated by the assertion."	7, noted: cription or a treatment or current and must be renewed onths or more frequently as sessment of the client by the I Health Professional."	{01050}			

6899



Protecting, Maintaining and Improving the Health of All Minnesotans

Email: MARYDVORAK6@GMAIL.COM

March 28, 2019

Ms. Mary Dvorak, Administrator Valley View Estates 1104 4th Avenue Northeast Long Prairie, MN 56347

Re: Enclosed State Licensing Orders - Project Number SL20675014

Informal Conference Requested

Dear Ms. Dvorak:

A survey of the Home Care Provider named above was completed on March 7, 2019 for the purpose of assessing compliance with State licensing regulations. At the time of survey, staff from the Minnesota Department of Health noted one or more violations of these regulations that are issued in accordance with Minn. Stat. 144A.43 to 144A.484. If, upon follow-up, it is found that the correction order(s) cited herein are not corrected, a fine for each order not corrected may be assessed in accordance with a schedule of fines described in Minn. Stat. 144A.474, subd. 11.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

DOCUMENTATION OF ACTION TO COMPLY

According to Minn. Stat. 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed. The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date. The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation

Valley View Estates March 28, 2019 Page 2

received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health. Homecare@state.mn.us; or, if you prefer you can mail it to:

> Home Care Correction Order Reconsideration Process Minnesota Department of Health/Health Regulation Division P.O. Box 3879 85 East 7th Place, Suite 220 St. Paul, Minnesota 55101

INFORMAL CONFERENCE REQUESTED

At any time, the Commissioner of Health is authorized by Minn. Stat. 144A.475, subd. 8 to hold an informal conference to exchange information, clarify issues, or resolve issues. The Department wants to schedule an informal conference call with you.

Please contact Jeri Cummins, Health Resource Supervisor, at (218) 302-6193 within seven (7) days of your receipt of this letter to schedule an informal conference to discuss your written plan of correction and lack of ongoing compliance as authorized by law. Please be prepared to let us know who, at your agency, we need to include in the informal conference and provide their contact information. We anticipate your cooperation as we work through this critical time.

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

Health Regulation Division

faula Mastran

Home Care & Assisted Living Program

DEPARTMENT OF HEALTH











Enclosure

cc: Cheryl Hennen, Office of the Ombudsman for Long Term Care

Todd County Social Services

PRINTED: 03/28/2019 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2010
NAME OF I				CTATE ZID CODE	1 03/0	7/2019
	PROVIDER OR SUPPLIER		AVENUE NO	STATE, ZIP CODE DRTHFAST		
VALLEY	VIEW ESTATES		AIRIE, MN (_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 000	Initial Comments		0 000			
	Determination of who corrected requires or requirements provious indicated below. Who contains several ite of the items will be compliance. INITIAL COMMENT Project #SL206750 On March 4, 5, 6, a Department's staff of the following correct the time of the survival.	VIDER LICENSING DER Minnesota Statutes, section 32, this correction order(s) has ant to a survey. The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far left column entir Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Column States, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. THE LETTER IN THE LEFT COLUMN STATUTES. THE LETTER IN THE LEFT COLUMN SUBDIVISION 11 (b)(1)(2)	oftware. I to e Care ber led "ID ber and e Statute lies" s the he state This as eyors' rrection. DING OF TO THIS ON FOR FATE UMN IS ESS AND EVEL	
0 265 SS=F	Standards Practice	2) Up-To-Date Plan/Accepted ement of rights. A person who	0 265	(~)(-)(-)		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		H20675	B. WING		03/0	7/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
0 265	receives home care (2) the right to rece according to a suita subject to accepted health cal	e services has these rights: ive care and services able and up-to-date plan, and re, medical or nursing an active part in developing,	0 265				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to provide services according to accepted health care, medical or nursing standards, by not completing a comprehensive assessment for bed rail use for one of one client (#2) with record reviewed.						
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect II of the clients). The findings					
	of bed rails, and the	ssessed for the functional use erisks/benefits of the bed rails with the client and/or the ive.					
	not limited to, osteo	noses that included, but were parthritis, a history of urinary I), and gout (a form of arthritis					

Minnesota Department of Health

STATE FORM 6899 11A911 If continuation sheet 2 of 89

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
				STATE, ZIP CODE PRTHEAST 56347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 265	caused by excess to Caused by excess to On March 5, 2019, employee E (unlice observed providing the bathroom. The bilateral (to both side the raised position. A review of client #2 Update Summary", that noted the client ensure safety with the and the assistance belt and walker whe addition, the summassistance with toile history of falls, and On March 6, 2019, employee A (admindirector of nursing) bed rails for client #0 of zone 1 (3/4 inches and the of zone 1 was 4 1/2 appeared to be secframe. Employee A with the bed, and the Client #2 was also if and reported she us out of the bed. Client #2's record la RN had assessed to bed rails, and the of the bed rails.	ge 2 Iric acid in the bloodstream). at approximately 7:25 a.m., nsed personnel/ULP) was personal cares for client #2 in client's bed was noted to have les) bed rails attached and in 2's record revealed a "Clinical dated December 21, 2018, to needed supervision to ransfers due to unsteadiness of one person with a transfer en transfering or walking. In ary noted client #2 required eting every two hours, had a was forgetful to day and time. at approximately 2:00 p.m., istrator, registered nurse/RN, was observed measuring the eta. The widest horizontal see guidance below) was 12 widest vertical measurement etinches. The bed rails urely attached to the bed reported the bed rails came the client doesn't use them. Interviewed at the same time, seed the bed rails to get in and acked evidence to indicate the he client for the functional use the risks and benefits of bed rails d with the client or the client's	0 265			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			,			
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 265	5 Continued From page 3		0 265			
	employee A reported clients with bed rail five clients, including the functional use of benefits of bed rails clients and/or the common the March 10, 200 and Human Services Administration (FDA System Dimensional noted the recommon the supplemental forms of the supplemental form	at approximately 3:00 p.m., and that the licensee had five is and verified that none of the ing client #2, were assessed for of bed rails, and the risks and is were not discussed with the lients' representatives. 6, U.S. Department of Health is and Food and Drug (A) publication, "Hospital Bed is all and Assessment Guidance", anded maximum dimensions to intrapment was 4 and 3/4 is rails (Zone 1).				
	2010, included the bed rails are used, assessment of the status, closely mon FDA also identified; with memory, sleep uncontrolled body r bed and walk unsaibe carefully assess them from harm, so the patient's health determine how bes The licensee's police Side Rails", dated Nalert the RN if a clies similar equipment a whether the side rail client. The RN will be representative and/risks related to side rail does not appear	to Bed Safety" revised April following information: "When perform an on-going patient's physical and mental itor high-risk patients. The "Patients who have problems sing, incontinence, pain, novement, or who get out of fely without assistance, must ed for the best ways to keep uch as falling. Assessment by care team will help to to to keep the patient safe." by "Assessing the Safety of March 5, 2017, noted "Staff will ent has any type of side rail or and the RN will then evaluate il appears to be safe for the educate the client, the client's for family members about the trails, and if the client's side recommend to the client, the client's to the client, the client's				

Minnesota Department of Health

STATE FORM 6899 11A911 If continuation sheet 4 of 89 Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		H20675	B. WING		03/07/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
0 265	5 Continued From page 4		0 265			
	members that the s will recommend altorisk of a fall out of to these conversations. No further information	client's involved family side rail shall be removed and ernative options to reduce the bed. The RN will document and recommendations." ion was provided. R CORRECTION: Seven (7)				
	day					
0 790 SS=C	Subd. 3. Quality maprovider shall engal appropriate to the sand relevant to the care provider provides. Tactivity means eval periodically reviewing client serother issues that hawhether changes in services need to be made in competent services to clients. management activity ears. Information about cavailable to the consurvey, investigation, or rerother than the consurvey of the consurvey.	ent is not met as evidenced	0 790			
	Based on interview	and record review, the				

Minnesota Department of Health

STATE FORM 6899 11A911 If continuation sheet 5 of 89

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	LETED	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER	1104 4TH	DRESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 790	activities appropriated provider, and relevation licensee provided, the staffing, or other provider to ensure staffing, or other providents. This practice resultativity violation that has not a minimal impact of health or safety), ar scope (when problet a systemic failure the potential to affect a clients). The finding During the entrance 2019, employee A (nurse/RN, director of licensee had not initiactivities and had management availar.	e to the size of the home care ant to the type of services the o evaluate the quality of care ther changes in services, ocedures needed to be made afe and competent services to ed in a level one violation (a potential to cause more than in the client and does not affect and was issued at a widespread ems are pervasive or represent nat has affected or has large portion or all of the gs include: e conference on March 4, administrator, registered of nursing) reported the tiated quality management o information about quality able at the time of the survey.				
0 805 SS=D	Subd. 6. Reporting adults and minors. must comply with re of maltreatment of the requirements for the	a) Reporting Maltrx of finors maltreatment of vulnerable (a) All home care providers equirements for the reporting minors in section 626.556 and e reporting of maltreatment of section 626.557. Each home	0 805			

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 805		olish and implement a written e that all cases of suspected	0 805			
	by: Based on interview licensee failed to in origin to determine the Minnesota Adul	and record review, the vestigate injuries of unknown if they should be reported to t Abuse Reporting Center f one client (#3) who sustained reviewed.				
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:					
	hand, and right hip, evidence of an inve	injuries to the left arm, left and the licensee lacked estigation to determine the own injuries and if a report MAARC.				
	arthritis, diabetes m #3's "Service Plan" indicated services t safety checks, beha	noses that included gouty nellitus, and dementia. Client , dated September 25, 2018, o include daily wellness and avior management, dressing ion administration, and				

Minnesota Department of Health

STATE FORM 6899 11A911 If continuation sheet 7 of 89

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DUILDING:			
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 805	Continued From pa	ge 7	0 805			
	medication setup.					
	December 17, 2018 assessment) noted abused, could be very	the client was at risk to be erbally abusive at times, was staff and other residents, and,				
	at 8:01 a.m., noted with a skin tear on the same day, emp noted on the same and fingers were browllen, and a large. The record indicate January 26, 2019, a	cort, dated January 27, 2019, the client came to breakfast the left arm. At 5:53 p.m., on loyee B (registered nurse/RN) form that client #3's left hand ruised, three fingers were be bruise was on the right hip. and at another time, he said he is a chair. A fall was not				
	and written by emp director of nursing) hand being very sw newly developing lo have him seen in the assessment and to	form, dated January 28, 2019, loyee A (administrator, RN, noted "At this point with his rollen, increase in falls, and lose incontinent stools, we will be clinic today for further rule out an underlying I be a contributing factor."				
	evidence an investi RN to determine ho the left hand injury, occurred. In additio	lacked documentation to gation was conducted by the bw the skin tear to the left arm, and bruising to the right hip n, the record lacked evidence own origin had been reported				
		at approximately 1:30 a.m., istrator, RN, director of				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 805	nursing) was interv licensee had not do injuries sustained be whether the injuries whether a report she Employee A confirm for client #3 were not limited to continue the interview of the work of the interview of the interview of the interview of the work of the interview of the work of	iewed and reported the one an investigation of the cy client #3 to determine is were unexplained and could be filed with MAARC. The of the unwitnessed injuries of reported to MAARC. at approximately 11:00 a.m., iewed regarding the incident ported he "falls many times", ow he hurt his hand or other bruises and abrasions difficult to determine how ew was reliable since it was dish e was saying were what due to his word-finding	0 805			

Minnesota Department of Health

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 805	Continued From pa	ige 9	0 805			
	make an oral repor had not followed the	RN or home care director will t to the CEP." The licensee eir policy to ensure that all ed injury or suspected reported.				
	No further informat	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 815 SS=D	144A.479, Subd. 7	Employee Records	0 815			
	provider must main paid employee, regularly providing home car individual contracto	records. The home care stain current records of each scheduled volunteers re services, and of each or providing home care rds must include the following				
	registration, or certification,	rent professional licensure, ification, if licensure, quired by this statute or other				
		tation, required annual training of training, and competency				
	(3) current job desc qualifications, respo staff providing supervision	onsibilities, and identification of				
	(4) documentation	of annual performance tify areas of improvement				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 815	Continued From pa	ige 10	0 815			
		roviding home care services, uired health screenings under				
		have taken place and the				
	(6) documentation required under sec	of the background study as tion 144.057.				
	Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed					
	by or under contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.					
	by: Based on interview licensee failed to er	ent is not met as evidenced and record review, the nsure the employee record ed content for one of one record reviewed.				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an is limited number of c limited number of s situation has occur findings include:	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The				
	The licensee lacked	d evidence an employee				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	03/0	1/2019
			AVENUE NO			
VALLET	VIEW ESTATES	LONG PR	AIRIE, MN 5	6347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
0 815	Continued From pa	ge 11	0 815			
	included a current j contained the requi and identification of and documentation review which identifineeded and training. Employee A (admin director of nursing) on May 20, 2014. Employee A's empl description that included above. In additional and included above.	istrator, registered nurse/RN, was employed by the licensee oyee record lacked a job uded the required content dition, the employee's record ion an annual performance				
	employee A verified required content for identification of staf addition, employee record lacked docu	at approximately 10:30 a.m., I her job description lacked the r qualifications and if providing supervision. In A verified her employee mentation of an annual v having been completed in				
	March 5, 2017, note "Personnel records organized and confithe home care law "2. The personnel reinclude:" "i. Performance eva of improvement need [performance review annually]; j. Current job descriptions."	cy "Personnel Records", dated ed: will be kept up-to-date, well idential and will comply with and other relevant laws." ecord for each person will aluations which identify areas eded and training needs ws must be conducted at least iption, which includes onsibilities and identification of				

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STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
JEAN ION ION INCLUDEN		A. BUILDING:				
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
0 815	Continued From pa	ge 12	0 815			
	supervisors."					
	No further informati	ion was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty One				
0 835 SS=A		3 Statement of Home Care	0 835			
	to the initiation of somust provide to the representative a wridentifies if the provides a basic or complete services the provided which services the the scope of the procare provider shall obtain from the clients that	prehensive home care license, ovider is authorized to provide, provider cannot provide under ovider's license. The home in written acknowledgment to the provider has provided the document why the provider				
	by: Based on interview licensee failed to prepresentatives a waservices which ider comprehensive hor services it was authorized three clients (#3) was a substitute of the comprehensive hor services it was authorized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clients (#3) was a substitute of the comprehensive horized three clie	and record review, the rovide to clients or client written statement of home care attified the licensee had a me care license and the norized to provide for one of ith records reviewed.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		02/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/0	7/2019
	VIEW ESTATES		AVENUE NO			
			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 835	Continued From pa	ge 13	0 835			
	health or safety), ar scope (when one or are affected or one	n the client and does not affect nd was issued at an isolated r a limited number of clients or a limited number of staff situation has occurred only indings include:				
	arthritis, diabetes m #3's "Service Plan" indicated services to safety checks, beha	oses that included gouty rellitus, and dementia. Client dated September 25, 2018, o include daily wellness and avior management, dressing ion administration, and				
	the client's represer statement which ide comprehensive hon	acked evidence the client or ntative were provided a written entified the provider had a ne care license and the ed under the license.				
	employee A (adminidirector of nursing)	at approximately 2:00 p.m., istrator, registered nurse/RN, verified client #3 had not nt of home care services as				
	Home Care Agency "The RN/Administra completion of the re of Health form entitl Services Comprehe	ey "Information About Our ", dated March 5, 2017, noted: ator assures the accurate equired Minnesota Department led "Statement of Home Care ensive Home Care Provider" cy, as it may be updated from				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty One				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
TAG	144A.4791, Subd. 8 and Monitoring Subd. 8. Comprehe monitoring, and reaservices being provided are comprended in person by a regist services are provided professionals, the aconducted by the atthis initial assessment client's residence of the client's residence of telecommunication standards that meets. 144A.4791, Subd. 8 and Monitoring, and reasessment client's residence of telecommunication standards that meets.	asc identifying information) B Comprehensive Assessment Ensive assessment, issessment. (a) When the rehensive home care services, itial assessment must be stered nurse. When the ed by other licensed health assessment must be propriate health professional, it in the number of home care services. If and reassessment must be ent's home no more than 14 rvices. In an item of the assessment as needed based on changes ent and cannot exceed 90 date of the assessment. The imay be conducted at the rithrough the utilization of methods based on practice at the individual client's needs. Entire in the individual client's needs. Entire in the individual client's needs. Entire in the individual client's needs.		CROSS-REFERENCED TO THE APPRO			
	licensee failed to comonitoring and reason changes in the rone client (#3) follow	and record review, the onduct ongoing client as needed based needs of the client for one of wing a fall, and failed to sessment within five days, and					

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/	07/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	DRESS, CITY, S AVENUE NO RAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 860	a reassessment with home care services In addition, the licer client monitoring are exceeding 90 days assessment for two with records review. This practice result violation that did no safety but had the polient's health or sa cause serious injury was issued at a pat limited number of a limited number of a limited number of situation has occurre found to be pervasional to the following three unwarious injuries. CHANGE IN CONECTION Client #3's record fanurse (RN) conduct assessment of the following three unwarious injuries. Client #3 had diagnarthritis, diabetes medicated services the safety checks, behave reminders, medicated services the safety checks, behave medication setup. Client #3's most recassessment, "Clinic December 17, 2018 history of falls. The 10" (a multi-factoria)	thin 14 days, after initiation of a for one of three clients (#4). Insee failed to provide ongoing and reassessment not from the date of the last of two clients (#2 and #3) ed. The died in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than staff are involved, or the red repeatedly; but is not ve). The findings include:				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	ORESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 860	dwelling patients) hindicated "resident has a steady gait. Hincontinent of urine score is 10." The Nith a score of 4 or Client #3 had docur January 27, 2019. JANUARY 27, 2019. JANUARY 27, 2019. An "other injury" repat 8:01 a.m., noted with a skin tear on the same day, empnoted on the same was bruised and he swollen fingers, and hip. The record indine thought he fell of another time, he sand chair. A fall was not "Resident Notes", oby employee B note physician and X-ray that indicated "one client would not allow the client also refut together or apply ic A "Resident Notes" 2019, written by emdirector of nursing) hand being very swonewly developing to have him seen in the assessment and to	ad been completed and is a risk for falls. He is a 4, but he scored 6 on this, he is at times, MACH is 8. His MAHC-10 indicated a fall risk more out of a 10 point scale. The mentation of three falls since port, dated January 27, 2019, the client came to breakfast the left arm. At 5:53 p.m., on loyee B (registered nurse/RN) form that client #3's left hand a had three bruised and the had three bruised and the large bruise on his right cated client #3 reported that in January 26, 2019, and at id he hurt it getting out of a	0 860			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
NAME OF PROV	/IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY VIEW	W ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Fur date ind phy lass a m FE An 2:2 cha sus MA A "I cortry clie Clie heat The (M/ em and - "I" - " - " - " - " - " ant ber hyp sec day On em did	ted February 4, 2 licated client #3 h ysician that day. ix (antihypertens month. BRUARY 24, 20 incident report, of the period of the stained. ARCH 4, 2019 Fall" report, date mileted by emploiding to grab a TV in tent and when he ent #3 sustained and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and to his left the most current "F AHC-10), dated and the most c	tion on the "Resident Notes", 2019, written by employee B, nad been seen by the Physician discontinued his live), and will see him again in 19 dated February 24, 2019, at ent #3 caught his foot in a dining room with no injuries 19 dd March 4, 2019, at 5:24 p.m., oyee B, noted the client was remote control from another pushed at that client, he fell. abrasions to the back of his elbow. Fall Risk Assessment" March 4, 2019, completed by ted client #3 had a score of 14 m." Ils in the past 3 months."	0 860			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	DRESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 860	assessment of clier following the unwith various injuries, cor and loose incontine On March 7, 2019, client #3 was intervinced above. Clien times", but doesn't robtained any of the on his body. It was of his interview was if the words he was to say due to his wodementia. INITIAL AND 14 DACLIENT #4 Client #4's record lacompleted an initial within five days after services, and a read days after initiation Client #4 was admit 6, 2018. The client's December 12, 2018 medication adminis all ADL's (activities "Medication Set up needed]. Client #4's record in assessment completed 14, 2018, (more that An additional assess December 26, 2019 admission). The client and control in the client and control in the client and control in the client assessment completed.	at #3 for a change in condition essed falls that resulted in hisistant low blood pressures, int stools. at approximately 11:00 a.m., sewed regarding the incidents it #3 reported he "falls many recall how he hurt his hand or other bruises and abrasions hard to determine how much reliable since it was unknown saying were what he intended ord-finding problem and AY ASSESSMENTS acked evidence the RN comprehensive assessment or initiation of home care assessment no more than 14 of services. Atted for services on December is service plan, dated attaion, assist of one staff with	0 860			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/	07/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
VALLEY	VIEW ESTATES		I AVENUE NO RAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 860	employee A verified completed within the client #4. CLIENT MONITOR Records for clients ongoing client moniconducted as need needs of the client afrom the last date of the client #2 had diagn not limited to, osted tract infections (UT caused by excess to the client #2's service administration, assi (activities of daily live Wellness Checks." Client #2's record in assessments comp 2018, August 26, 20 the last assessment (more than 90 days The client's record monitoring and reast required. CLIENT #3 Client #3's record in assessments comp 2018, and Decemb days from the last a record lacked evided.	at approximately 1:15 p.m., I the assessments were not e required time frame for ING AND REASSESSMENT #2 and #3 lacked evidence itoring and reassessment was ed based on changes in the and did not exceed 90 days if the assessment. Incoses that included, but were earthritis, a history of urinary I), and gout (a form of arthritis uric acid in the bloodstream). Incolan, dated September 25,	0 860			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		H20675	B. WING		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
0 860	Continued From pa	ge 20	0 860				
	On March 5, 2019, at approximately 1:15 p.m., employee A verified the reassessments were not completed within the required time frame for clients #2 and #3. The licensee's policy "Monitoring of Clients and Their Services", dated March 5, 2017, noted "The RN must monitor and reassess the client in the client's home no more than 14 days after initiation of Comprehensive home care services by our agency, and therafter the monitoring and reassessment visits cannot exceed 90 days from the date of the last visit. The RN will determine the frequency of monitoring and reassessment visits based on the client's needs and the complexity of the client's services at a minimum of every 90 days."						
	No further informati	on was provided.					
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					
0 865 SS=E	144A.4791, Subd. 9 Implementation & F	9(a-e) Service Plan, Revisions	0 865				
	revisions to service days after the initiation of	an, implementation, and plan. (a) No later than 14 f services, a home care se a current written service					
	include a signature home care provider and b	n and any revisions must or other authentication by the by the client or the client's umenting agreement on the					

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	H20675		B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO			
			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 865	Continued From pa	ge 21	0 865			
	services to be provided. The servi needed, based on counder subdivisions 7 and information to the coprovider's fee for services and the Ombudsman for (c) The home care provide all services service plan. (d) The service plan	ce plan must be revised, if client review or reassessment 8. The provider must provide lient about changes to the distribution for Long-Term Care. provider must implement and required by the current				
	must be entered into the client's record, including notice of a change in a client's fees when applicable.					
	(e) Staff providing home care services must be informed of the current written service plan.					
	by: Based on observatireview, the licenses plan based on clien	ent is not met as evidenced on, interview, and record e failed to revise the service t review or reassessment for (#2, #4, #10) with records				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a pat	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	-	
VALLEY	VIEW ESTATES		I AVENUE NO RAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	situation has occurr found to be pervasioned to be pervasioned the client when a change in such that the contract infections (UT) caused by excess the client #2's service administration, assioned (activities of daily live Checks". Client #2's "Clinical by employee B (regulating. Resident harresident at risk for a done hourly." The contract infections (UT) caused by excess the contract infection (UT) caused by excess the contract infections (UT) caused by excess the contract infection (UT) caused by excess the contract infection (UT) caused by excess the contract infections (UT) caused by excess the contract infection (UT) caused by excess the contract infections (UT	staff are involved, or the red repeatedly; but is not ve). The findings include: #2, #4, and #10 lacked service plans where revised	0 865			
	(occurs when the b	oses that included stroke lood supply to part of the brain luced, depriving brain tissue of				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	ORESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 865	oxygen and nutrient Client #4's service p 2018, noted service administration, assi (activities of daily liv by RN weekly and R lacked evidence of by the RN. The clie updated when the of services. On March 6, 2019, employee A verified not been updated to receive medication verified client #4 do medication setup by that "staff doesn't re receiving medication have her medication CLIENT #10 Client #10 had diag prostatic hypertroph and dementia. Client #10's service 2017, noted service staff with all ADL's (Client #10's record completed by emplo 15, 2018, that noted medications." The of dated January 11, 2 Client #10's service	clan, dated December 12, es that included medication st of one staff with all ADL's ving), and "Medication Set up PRN". The client's record services for medication setup nt's service plan was not client had a change in at approximately 3:00 p.m., client #4's service plan had be reflect the client did not setup. Employee A also es not currently receive the RN. Employee A reported ecall when [client #4] stopped in set up, or if she ever did in set up, or if she ever did in set up, or if she ever did in set up by the RN." Inoses to include benigh in the plan, dated September 28, es that included assist of one factivities of daily living). Included a "Clinical Update" by ee G (RN), dated November down and the plan in the plan in the plan in the plan in the prescriber orders, and in the plan in the plan in the prescriber orders, and in the plan in the prescriber orders, and in the plan in the pla	0 865			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED	
AND LEAN	C. COLLICOTION	DENTILION TON NOMBER.	A. BUILDING:		GOIVII LETED		
		H20675	B. WING 03/		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES	1104 4TH	AVENUE NO	PRTHEAST			
VALLET	LONG P			56347			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
0 865	Continued From page 24		0 865				
	employee D (unlice observed administer along with water and (a thickener added swallowing disorder) On March 7, 2019, employee A verified not been updated so September 25, 201	at approximately 8:30 a.m., nsed personnel/ULP) was bring medications to client #10 di juice thickened with "thick-it" to liquids for persons with a r). at approximately 9:00 a.m., I client #10's service plan had ince it was completed on 8, to include the change in the diquids and medication					
	The licensee's polic of the Service Plan "All home care servaccordance with a service plan, based needs and preferer "3. a. Each client's RN, therapist, or ot professional (as ap i. During each regulation which occurs at least ii. Whenever changes to be provided becard condition, after recent from the client's phyprovider, following a client's return from "b. If a review of the client's service on the client's need fees, the RN, therat health professional necessary changes revised service plan	service plan is reviewed by the her licensed health plicable), as follows: llar client monitoring visit,					

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER	1104 4TH	DRESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	plan." No further informati	and date the revised service	0 865			
0 870 SS=F	(f) The service plant (1) a description of provided, the fees f of each service, accorreview or assessment (2) the identification staff who will provided (3) the schedule and reviews or assessment (4) the frequency of staff and type of perstaff; and (5) a contingency person (i) the action to be the provider and by the representative if the scheduled service of (ii) information and client's representation provider; (iii) names and continuous according to the service of the scheduled service of (iii) information and client's representation to the scheduled service of (iii) information and client's representation and client's representation and client's representation and continuous and continuous according to the service of (iii) information and continuous and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and continuous according to the service of (iii) information and (iiii) information and (iiii) information and (iiiii) information and (iiiii) information and (iiiii) information and (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	the home care services to be or services, and the frequency ding to the client's current ent and client preferences; of the staff or categories of the services; did methods of monitoring nents of the client; sessions of supervision of the services who will supervise that includes: aken by the home care client or client's	0 870			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VALLEY VIEW ESTATES 1104 4TH LONG PE			PRTHEAST 6347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
0 870	Continued From page 26		0 870			
	client's condition, in information as to who has authorized emergency; and (iv) the circumstant medical services are consistent with chapters 145B and by the client under This MN Requirements by: Based on observation review the licensee included the requirements.	ant adverse change in the cluding identification of and prity to sign for the client in an eas in which emergency is not to be summoned. 145C, and declarations made those chapters. ent is not met as evidenced on, interview and record failed to ensure service plans and content for five of five #5, #10) with records.				
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: Service plans for clients #2, #3, #4, #5, and #10 lacked the required content. CLIENT #2 Client #2 had diagnoses that included, but were not limited to, osteoarthritis, a history of urinary tract infections (UTI), and gout (a form of arthritis caused by excess uric acid in the bloodstream).					

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Minnesota Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.111	o. coo		A. BUILDING:			
		H20675	B. WING		03/0	7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 870	administration, assi (activities of daily ling Checks". The client following required or a client's current reviews are contact the home of the following arthritis, diabetes or and safety checks, dressing reminders and medication set lacked the following a contact information to have notified in a significant adverse condition, including contacting frequency place and safety checks, dressing reminders and medication set lacked the following and medication of the provided (diabetic of the complete schemonitoring reviews and the following of the contact information to have notified in a significant adverse condition, including	es that included medication ist of one staff with all ADL's ving), daily "Safety & Wellness is service plan lacked the content: each service, according to the ew or assessment and client dicurrent frequency of promboembolism-deterrent eatment of edema). edule and methods of or assessments of the client, uency of sessions of and, in that included information and intoriclient's representative to are provider. Plan" dated September 25, vices to include daily wellness behavior management, medication administration, up. The client's service plant grequired content: e home care services to be diet), edule and methods of or assessments of the client, uency of sessions of	0 870			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VALLEY VIEW ESTATES 1104 4TI LONG P			ORTHEAST 66347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 870	(occurs when the b is interrupted or recoxygen and nutrien Client #4's service 2018, noted service administration, ass (activities of daily liby RN weekly and service plan lacked content: The complete schmonitoring reviews The accurate frequency plate be taken by the hor client or client's repservice could not be and contact information as to work client in an emerge CLIENT #5 Client #5 had diagred, high blood pressure (CHF-a condition in the content or condition in the content in the condition in the conditio	noses that included stroke blood supply to part of the brain duced, depriving brain tissue of its). plan, dated December 12, es that included medication ist of one staff with all ADL's ving), and "Medication Set up PRN" [as needed]. The client's I the following required needule and methods of or assessments of the client, juency of sessions of and in that included: the action to me care provider and by the presentative if the scheduled e provided; and the names ation of persons the client ified in an emergency or if ant adverse change in the including identification and ho had authority to sign for the	0 870	BEI IOIENOT)		
	2018, noted service	plan, dated September 25, es that included medication ist with all ADL's, oxygen edication setup.				

Minnesota Department of Health

STATE FORM 6899 11A911 If continuation sheet 29 of 89

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	DRESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 870	The client's service required content: - The identification staff who would prothe frequency of the The complete schmonitoring reviews - The accurate freq supervision of staff, - A contingency planand information as for the client in an example of the client in an example of the client #10 had diag prostatic hypertrophand dementia. Client #10's service 2017, noted service staff with all ADL's (client's service plancontent: - A description of the	plan lacked the following of the staff or categories of vide oxygen assistance, and e oxygen asistance; edule and methods of or assessments of the client, uency of sessions of and n that included identification to who had authority to sign	0 870			
	management), - The identification staff who would pro - The complete sch monitoring reviews - The accurate freq supervision of staff, - A contingency plar and information as for the client in an element of the client of the cl	of the staff or categories of vide the oxygen assistance; edule and methods of or assessments of the client, uency of sessions of and n that included identification to who had authority to sign				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D 14/11/0			
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
		LONG PR	AIRIE, MN 5	66347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 870	Continued From page 30		0 870			
0 870	content was not inciclents #2, #3, #4, # sure all of our clients schedule and meth- assessments of the supervision of the u The licensee's policy Plans", dated Marchylan established aftindividualized initial subsequent reasse a. A description of the including nursing and services, treatment be provided by our b. The frequency of the client's current ac. The fees for the lagency is providing d. Identification of the identification of the identification of the identification of the identification staff that will provided f. The schedule and reviews or re-assesting. The frequency of the schedule and reviews or re-assesting.	luded in service plans for 15 and #10 and stated "I'm 15 are missing the complete ods of monitoring reviews or 16 client and the frequency of 17 client and the frequency of 18 client and the Service of 18 client and the Service of 18 client and each 18 client an	0 870			
	(i) the action to be t and/or client's repre- service cannot be p	aken by our agency, the client esentative if the scheduled provided;				
	client's representati (iii) Names and con the client wishes to or if there is a signif	a method for a client or ve to contact our agency. tact information of persons have notified in an emergency ficant adverse change in the cluding identification of and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 870	Continued From page 31		0 870			
	client in an emerge (iv) The circumstan medical services ar pursuant to provide No further informati	ces in which emergency re not to be summoned r orders related thereto."				
0 905 SS=F	Services Subd. 2. Provision of	2 Provision of Medication Mgt	0 905			
	services. (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment of determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.					
	needed in manager diversion of medica who may have acce "Diversion of	t must identify interventions ment of medications to prevent tion by the client or others ess to the medications. s the misuse, theft, or illegal				

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Minnesota Department of Health

AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 905	Continued From pa or improper disposi		0 905			
	by: Based on interview licensee failed to er conducted a face-to providing medicatio determine what me would be provided a	ent is not met as evidenced and record review, the nsure a registered nurse (RN) oface assessment, prior to n management services, to dication management services and how the services would be of three clients (#2, #3, #4) with				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a t harm a client's health or obtential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings				
	evidence the RN has assessment with the representative to in review of all medication effects, contraindicate reactions, and intermanagement of medications. In a evidence an assess	#2, #3 and #4 lacked ad conducted a face-to-face e client or the client's clude an identification and ations the client was known to as for the medications, side ations, allergic or adverse ventions needed in the edications to prevent diversion addition, client #4 lacked sment was completed prior to a management services.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO RAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 905	Continued From pa	ge 33	0 905			
	osteoarthritis, histor	oses which included ry of urinary tract infections, arthritis caused by excess dstream).				
		olan, dated September 25, es that included medication				
	The client's current medications managed by the licensee included: one medication for dementia, two antihypertensives, two vitamins, one antiinflammatory, one cholesterol medication, and one non-narcotic analgesic. Client #2's record included a "Clinical Update Summary", completed by employee B (RN), dated December 21, 2018, which noted the client "Needs help taking medications (Med admin) RN monitors and sets up medication." And, "Med Self-Admin is not applicable."					
	The client's record assessment was corequired content no	empleted to include the				
		oses which included gouty rellitus and dementia.				
	licensee included: a	medications managed by the a medication for gout, a ent, an antidepressant, an d a blood thinner.				
	Update Summary"	B's record revealed a "Clinical dated December 17, 2018, by employee B (registered				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/07/2019	
					03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER		AVENUE NO	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 905	Continued From page 34		0 905			
	nurse/RN) and noted the client "Needs full medication management and set up." And, "Med Self-Admin is not applicable."					
	The client's record lacked evidence an assessment was completed to include the required content noted above.					
	On March 5, 2019, at approximately 1:30 p.m., employee A reported the licensee had not conducted a face-to-face medication assessment with any of the licensee's clients to include the required content noted above.					
	CLIENT #4 Client #4 was admitted for services on December 6, 2018, and had diagnoses which included stroke (occurs when the blood supply to part of the brain is interrupted or reduced, depriving brain tissue of oxygen and nutrients).					
	Client #4's service plan, dated December 12, 2018, noted services that included medication administration, assist of one staff with all ADL's (activities of daily living), and "Medication Set up by RN weekly and PRN" [as needed].					
	licensee included: o medication, one an	medications managed by the one cholesterol lowering tidepressant, five vitamin antihypertensives, and an				
	Update Summary" dated December 14 "Needs help taking And, "Med Self-Adriclient's record lacket	ncluded an initial "Clinical completed by employee B, 4, 2018, which noted the client medications (Med Admin)." nin is not applicable." The ed evidence an assessment or to the provision of				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER	1104 4TH	ORESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 905	medication manage the required content on March 5, 2019, employee A (admin nursing) verified that for client #4 was not medication manage lacked an assessm required content. The licensee's police Individualized Medication decividualized Medication manage including an assessmedication manage individualized medication manage individualized medication manage individualized medication the client in conjunct client's representation. The policy did not in would be completed management service would include an idmedications the client and would include in side effects, contrain reactions, and action.	ement services, and included to noted above at approximately 3:15 p.m., istrator, RN, director of at a medication assessment to completed prior to providing ement services and the client ent which included the by "Development of the cation Management Plan and cation Record," dated March on of the nursing assessment, ement of the client's need for ement, the RN develops an cation management plan for cition with the client and/or the ve." Indicate that the assessment desorted before medication es were provided or that it entification and review of all ent was known to be taking, indications, allergic or adverse and to address these issues.	0 905			
0 910 SS=D		3 Individualized Medication ss	0 910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 910	Continued From pa	ge 36	0 910			
	reassessment. The provider must moni medication manage under subdivision 2 when symptoms or other	zed medication monitoring and comprehensive home care tor and reassess the client's ement services as needed the client presents with issues that may be and, at a minimum, annually.				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure ongoing monitoring and reassessment was conducted for changes in medication administration for two of three clients (#3 and #4) with records reviewed.					
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:					
	nurse (RN) monitor medication manage when the client's lat increased voiding to blood pressure) wa falls and low blood					
		oses that included dementia Client #3's "Service Plan",				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF PR	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY V	IEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	nclude daily wellnesse behavior management administration administration administration administration administration administration administration and reassessed the noted "Takes diuretion and reassessed the noted "Takes diuretion and reassessed administration and reassessed and adverse effects of noted "Takes diuretion adverse effects of non March 7, 2019, a semployee A (adminituring) verified the client #3's medication and reas and agement services and and reas and agement services and and reas and agement services and adminitured and reas and agement services and adminitured and reas and agement services and a coccurs when the billient #4 had diagnated and agement and a coccurs when the billient #4 had diagnated and agement and a coccurs when the billient #4 had diagnated and a coccurs when the billient #4 had dia	5, 2018, indicated services to se and safety checks, ent, dressing reminders, tration, and medication setup. d prescriber's orders, dated at included the discontinuation ensee had informed the ent falls," ?? [question] if B/P ops and he gets dizzy." acked any additional vidence the RN had monitored eclient regarding medications s. Summary", dated December d by employee B (RN) still ic medication. Client is cation compliance and staff etency. Client is monitored for nedication as well." at approximately 10:30 a.m., strator, RN, director of elicensee did not reassess ons after the discontinuation of acked evidence the RN sessed the client's medication setup by the RN. coses that included stroke ood supply to part of the brain uced, depriving brain tissue of	0 910			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	DRESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 910	Client #4's service process administration, assi (activities of daily live by RN weekly and Frecord lacked docuby the RN. A "Clinical Update Stocked (RN), dated Decembrul medication mandon March 6, 2019, employee A verified medication setup by A reported that "stated "44"] stopped needing ever did." Employee did not reassess clical as required. The licensee's policity individualized Medical Individual Indiv	plan, dated December 12, es that included medication st of one staff with all ADL's ving), and "Medication Set up PRN" [as needed]. Client #4's mentation of medication setup ber 26, 2018, noted "Needs agement and set up." at approximately 3:00 p.m., I client #4 does not receive y the RN currently. Employee ff doesn't recall when [client g medication setup, or if she e A also verified the licensee ent #4's medication services by "Development of the cation Management Plan and cation Record," dated March sthat each client's cation Management Plan is I consistent with prescriber's needs and preferences of the enter and reassess the client's enemt services: a nurse's periodic monitoring of 90 days or more frequently judgement); and oresents with symptoms or any be medication related."	0 910			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER	1104 4TH	DRESS, CITY, S AVENUE NO BAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 910	Continued From page 39		0 910			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 920 SS=D	144A.4792, Subd. 5 Mgt Plan	5 Individualized Medication	0 920			
	Subd. 5. Individualized medication management plan. (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:					
	management service (2) a description of on the client's need diversion, and considerations; (3) documentation of relating to the admit (4) identification of monitoring medication refills are (5) identification of tasks that may be opersonnel; (6) procedures for some a problem arises with the control of th	ceribing the medication ces that will be provided; storage of medications based is and preferences, risk of istent with the manufacturer's of specific client instructions instration of medications; persons responsible for ion supplies and ensuring that the ordered on a timely basis; medication management delegated to unlicensed elicensed health professional of the medication management the medication management with medication management of the medication of the medica				
	services; and (7) any client-specif	ic requirements relating to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	1,2010	
VALLEY	VIEW ESTATES		AVENUE NC AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
0 920	documenting medicity verifications that all medications prescribed, and mo prevent possible complications or ad (b) The medication current and updated changes. This MN Requiremed by: Based on interview licensee failed to medication manage the services provide with records review. This practice results violation that did not safety but had the policient's health or saccause serious injury was issued at an isolimited number of colimited number of colimited number of situation has occurrifindings include: Client #4's medication setup by Client #4 had diagn (occurs when the bis interrupted or recoxygen and nutrients)	cation administration, are administered as nitoring of medication use to liverse reactions. management record must be d when there are any ent is not met as evidenced and record review, the aintain an individualized ement plan that was current for ed for one of three clients (#4) ed. ed in a level two violation (a t harm a client's health or otential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The ion management plan was not slient no longer required y the RN. oses that included stroke lood supply to part of the brain luced, depriving brain tissue of	0 920				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
				STATE, ZIP CODE PRTHEAST 66347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 920	2018, noted service administration, assi (activities of daily liv by RN weekly and Frecord lacked docurby the RN. A "Clinical Update S (RN), dated Decemfull medication man On March 6, 2019, employee A verified receive medication reported that "staff stopped needing midid." Employee A anot update the medication required when medication discontinued. The licensee's policity individualized Medical Individual I	es that included medication st of one staff with all ADL's ving), and "Medication Set up PRN" [as needed]. Client #4's mentation of medication setup Summary", by employee B ber 26, 2018, noted "Needs agement and set up." at approximately 3:00 p.m., I client #4 does not currently setup by the RN. Employee A doesn't recall when [client #4] edication setup, or if she ever lso verified the licensee did lication management plan as dication management Plan and cation Record," dated March sthat each client's cation Management Plan is I consistent with prescriber's needs and preferences of the initor and reassess the client's enurse's periodic monitoring of 90 days or more frequently judgement); and presents with symptoms or any be medication related."	0 920			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 920	Continued From pa	ge 42	0 920			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 940 SS=F	144A.4792, Subd. 9 Medication Setup	Documentation of	0 940			
	Documentation of coname of medication, quaradministered, route of person completing medicatime of setup. This MN Requirements by: Based on observation review, the licenses of the medication, cadministered, and to	ation of medication setup. dates of medication setup, ntity of dose, times to be of administration, and name tion setup must be done at the ent is not met as evidenced on, interview, and record e failed to document the name quantity of dose, times to be he route of administration at ion setup for two of two clients cords reviewed.				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a t harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect ll of the clients). The findings				
	client #2's medicati	at approximately 7:25 a.m. ons were observed with nsed personnel/ULP) to be in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 940	Continued From pa	ge 43	0 940			
	a locked cabinet in medications were p					
	February, and Marc and was document initial of the nurse of one day of each we to note the names of dose, times to be a	Summary" for January, ch 2019, noted "Med setup" ed as provided weekly by an doing the medication setup on eek. The documentation failed of medications, quantity of dministered, and the route of e medications the RN had				
	CLIENT #3 On March 5, 2019, at approximately 7:45 a.m. client #3's medications were observed with employee E to be in a locked cabinet in his bathroom. The medications were all in bubble packs from the pharmacy except for the client's warfarin (blood thinner) which was preset in a weekly dosage box. Employee E indicated the warfarin had been setup by an RN.					
	February, and Marc and was document initial of the nurse of one day of each we to note the name of dose, time to be ad	Summary" for January, ch 2019, noted "Med setup" ed as provided weekly by an doing the medication setup on ek. The documentation failed f the medication, quantity of ministered, and the route of e medication the RN had				
	employees A (admi nursing) and B (RN the warfarin for clie	at approximately 3:00 p.m., nistrator, RN, director of l) verified employee B setup nt #3 and did not document ed. In addition, employees A				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		H20675	B. WING		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
0 940	Continued From page 44		0 940				
	five clients and had the medications, quadministered, and t	censee setup medications for In't documented the name of Juantity of dose, times to be the route of administration of ERN had setup for any of the					
	System-Dosage Bo 2017, noted: "7. When the RN or nurse] has complet into the Dosage Bo each individual med	cy, "Medication Administration ox Set-Up", dated March 5, r LPN [licensed practical ed setting up the medications x, the nurse will document dication that has been set up ation Administration Record]."					
	No further informati	ion was provided.					
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					
0 950 SS=F	144A.4792, Subd. Clients - Unplanned	10(b) Medication Mgt for	0 950				
	nurse is not availab	ime away when the licensed ble, the registered nurse may be unlicensed personnel if:					
	unlicensed staff and staff is	urse has trained the d determined the unlicensed the procedures for giving hts; and					
	procedures for the including any special instruct	urse has developed written unlicensed personnel, ions or procedures regarding ses that are prescribed for the					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 950	O Continued From page 45		0 950			
	client.					
	The procedures must address:					
	(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;					
	(ii) how the container or containers must be labeled;					
	(iii) the written information about the medications to be given to the client or client's representative;					
	(iv) how the unlicensed staff must document in the client's record that medications have been given					
	including document were given to	client's representative, ting the date the medications				
		ent's representative and who ations, the person who gave				
	medications to the	client, the number of ere given to the client, and				
	medications have be client's representation nurse needs to be a medications are	red nurse shall be notified that been given to the client or live and whether the registered contacted before the or the client's representative;				
	completion of this to	registered nurse of the ask to verify that this task was bely by the unlicensed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/	07/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	ORESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 950	personnel. This MN Requirements: Based on interview licensee failed to er (RN) developed wripersonnel (ULP) who management for cliaway, and determine perform the proced failed to document gave the medication client (#4) with reconstitution that did no safety but had the polient's health or sacause serious injury was issued at a wide problems are pervate failure that has affer a large portion or all include: FAILURE TO DEVE On March 4, 2019, conference, at approximate A (administrator, RN the ULP had been polients having unplay wasn't available. En had not developed to unlicensed personn instructions or processubstances that we	and record review, the insure the registered nurse ten procedures for unlicensed to provided medication ents having unplanned time red competency for ULP to ure. In addition, the licensee the name of the person who as to the client for one of one ords reviewed. The din a level two violation (at harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and respread scope (when a sive or represent a systemic cted or has potential to affect I of the clients). The findings ELOP PROCEDURE during the entrance oximately 9:10 a.m. employee N, director of nursing) reported providing medications for anned time away when a nurse imployee A verified the licensee written procedures for the relational procedures for the relational procedures for the relational procedures for the client. CATE ULP TO SET UP	0 950			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	ORESS, CITY, S AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 950	On March 6, 2019, employee A verified education regarding unplanned time awahad not determined competent to follow medications to client FAILURE TO DOCI Client #4's record ladocumentation of mime away from the A "Medication Setup 2019, was unsigned medication to the cliperson. The documentation were to be administ 2019, one medications were to person. The documentation were to be administ 2019, one March 1, 2 medications were to p.m., on March medications were sepruary 28, 2019. documented as given member on March not indicate the person to the client. On March 5, 2019, employee A was as given the medication the facility on March she did not know widay and verified the	at approximately 1:00 p.m., the licensee had not provided providing medications for ay for the unlicensed staff and the unlicensed staff were the procedures for giving ats. JMENT CORRECTLY acked complete medication setup for planned	0 950			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 950	The licensee's police Who Will be Away Medications are Sc 2017, noted: 4.a. "The RN will est unlicensed staff to to the client or client when the client will "b. The RN may de staff if: i. The RN has traine unlicensed staff on giving medications from home when mii. The RN has writt unlicensed staff to 6. "When licensed medications to a clito take when the cliwhen the medicatione "d) The name and to gave the medication representative." No further information	cy "Medications For a Client From Home When heduled," dated March 5, stablish written procedures for follow when giving medications it's representative to take be away from home." legate this task to unlicensed ed and competency tested the procedures to follow when to clients who will be away redications are scheduled. en procedures for the follow." or unlicensed staff gives ent or client's representative ient will be away from home ons are scheduled, the staff ent the following:" citle of the staff person who are to the client or client's	0 950			
01000 SS=E	Subd. 20. Prescript prior to being set up administration, mus container in which i pharmacy bearing t	20 Prescription Drugs ion drugs. A prescription drug, of for immediate or later at be kept in the original true was dispensed by the che original prescription labelation including the expiration or a time-dated drug.	01000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01000	Continued From pa	age 49	01000			
	by: Based on observatifailed to monitor the time-dated drugs for #9) receiving medic licensee failed to more prescription label wincluding the expiratime-dated drug for medication review. This practice result violation that did not safety but had the policient's health or sa cause serious injur was issued at a parlimited number of a limited number of situation has occur	ent is not met as evidenced ion and interview, the licensee e beyond-use date of or three of ten clients (#7, #8, cation services. In addition, the naintain the original with legible information ation or beyond-use date of a rone of ten clients (#6) during ed in a level two violation (a ot harm a client's health or cotential to have harmed a dety, but was not likely to y, impairment, or death), and tern scope (when more than a elients are affected, more than a staff are involved, or the red repeatedly; but is not ive). The findings include:				
	MEDICATIONS On March 6, 2019, the storage of med licensee in the assi employee C (regist that the following m - metoprolol (decre (milligrams) for clie January 18, 2019 ibuprophen (antiin for client #9 had an 2019 ibuprophen 200 m expiration date of A	at approximately 1:30 p.m., ications managed by the sted living were observed with ered nurse/RN). It was noted nedications had expired: ases blood pressure) 25 mg nt #7 had an expiration date of a flammatory/analgesic) 200 mg a expiration date of February ng for client #8 had an august 2012.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		H20675	B. WING		03/0	7/2019		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
VALLEY	VALLEY VIEW ESTATES 1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE		
01000	Continued From pa	ge 50	01000					
	650 mg (stock med of April 2018.	ication) had an expiration date						
	were expired and ve	d the medications noted above erified the licensee lacked a ring expiration dates of the anage.						
	FAILURE TO MAINTAIN THE LEGIBILITY OF THE ORIGINAL PRESCRIPTION LABEL On March 6, 2019, at approximately 1:30 p.m., the storage of medications managed by the licensee in the assisted living were observed with employee C. It was noted that the following medications had black thick writing on the label that covered the expiration date of time-dated drugs for the following medications for client #6: - metoprolol 25 mg; and - Prinivil (lowers blood pressure).							
		d the medications noted above ion dates on the original						
	System-Dosage Bo 2017, noted: "5. When setting up check the expiration will identify if a pres in the near future as	cy "Medication Administration x Set-Up", dated March 5, o medications, the nurse will n date of the medication and acription needs to be renewed and will follow up with the harmacy if a new prescription						
	dated March 5, 201 "b. Until medication later administration must be kept in its of	cy "Storage of Medications", 7, noted: is set up for immediate or by a nurse, a legend drug original container bearing the label with legible information						

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/07/2019		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		. = • . •	
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
01000	Continued From page 51		01000				
	strength and quanti time-dated drug, dir prescriber's name,	tion number, name of drug, ty of drug, expiration date of rections for use, client's name, date of issue and the name licensed pharmacy that issued					
	No further information was provided.						
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					
01030 SS=F	144A.4793, Subd. 2	2 Policies and Procedures	01030				
33=F	comprehensive hor treatment and thera must develop, imple up-to-date written tr management policie policies and proced under the supervision registered nurse or	es and procedures. The lures must be developed on and direction of a appropriate licensed health tent with current practice					
	address requesting prescriptions for tre providing the treatm of treatment or ther communicating with therapy they are recommunicating they are recommunicating with the second control of the second	cies and procedures must and receiving orders or atments or therapies, nent or therapy, documenting apy activities, educating and a clients about treatments or ceiving, monitoring and ment and therapy, and a the prescriber.					
	This MN Requirements	ent is not met as evidenced					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01030	Based on interview licensee failed to do maintain up-to-date management polici documenting of tree educating and com treatments or thera monitoring and eva therapy with record. This practice result violation that did no safety but had the policient's health or sa cause serious injury was issued at a wide problems are pervatailure that has affeed affect a large portion findings include: A review of the licent management policient the required content treatment or therapy communicating with therapy they are revealuating the treatment of nursing) developed, implem written treatment and policies and proceed documenting of treatments are presentatives about the representatives about the representatives and representatives are representatives.	and record review the evelop, implement, and written treatment or therapy es and procedures to address atment or therapy activities, municating with clients about py they are receiving, and luating the treatment and s reviewed. ed in a level two violation (a tharm a client's health or obtential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when sive or represent a systemic cted or has the potential to in or all of the clients). The insee's treatment and therapy es revealed that they lacked at to address: documenting of y activities; educating and in clients about treatments or ceiving; and monitoring and ment and therapy. at approximately 1:15 p.m., istrator, registered nurse/RN, verified the licensee had not ented, or maintained current and therapy management lures that included atment or therapy activities,	01030			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO			
		LONG PRA	AIRIE, MN 5		DNI .	(7/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
01030	Continued From pa	ge 53	01030			
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01035 SS=F	144A.4793, Subd. 3 Treatment/Therapy		01035			
	management plan. management of orc or therapy services care provider must service plan a writte or therapy services client. The provider maintain a current i	red treatment or therapy For each client receiving dered or prescribed treatments the comprehensive home prepare and include in the en statement of the treatment that will be provided to the must also develop and individualized treatment and ent record for each client which st the following:				
	(1) a statement of t provided;	he type of services that will be				
	(2) documentation or relating to the treating administration;	of specific client instructions ments or therapy				
		treatment or therapy tasks that unlicensed personnel;				
	appropriate license	notifying a registered nurse or d health professional when a treatments or therapy				
	documentation of tr	ric requirements relating to reatment and therapy				

6899

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675				03/07/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/0	7/2019	
			AVENUE NO	•			
VALLEY	VIEW ESTATES	LONG PR	AIRIE, MN 5	66347			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
01035	Continued From page 54		01035				
	monitoring of treatment or therapy be current and updatchanges. This MN Requirement by: Based on observtion review, the licensee maintain a current in therapy management clients (#2, #3, #5 and licensee failed to proservice plan a writter or therapy services.	stered as prescribed, and nent or therapy to prevent ons or adverse reactions. The y management record must ated when there are any ent is not met as evidenced in, interview, and record a failed to develop and individualized treatment and ent record for four of four and #10). In addition, the repare and include in the en statement of the treatment that was being provided to the r clients (#3 and #10) with					
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are pervafailure that has affe a large portion or al include: INDIVIDUALIZED T MANAGEMENT PL Records for clients evidence individuali management plans required content as procedures for no appropriate licensee	#2, #3, #5 and #10 lacked zed treatment and therapy were developed to include the					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	AIRIE, MN 5	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 55	01035			
	documentation of tr verification all treati administered as pre	requirements relating to reatment and therapy received, ment and therapy was escribed, and monitoring of y to prevent possible lyerse reactions.				
	CLIENT #2 Client #2's diagnoses included osteoarthritis, history of urinary tract infections, and gout (a form of arthritis caused by excess uric acid in the bloodstream).					
	Client #2 had prescriber's orders, dated October 10, 2018, for Ace wrap (an elastic bandage used to decrease swelling and protect joints) to knee PRN (as needed).					
	Client #2's record la individualized treatr management plan t noted above.					
	CLIENT #3 Client #3 had diagn diabetes mellitus, a	oses that included dementia, nd gouty arthritis.				
		riber's orders, dated May 8, cose monitoring twice a week				
	January 28, 2019, t - Buddy tape and ic	onal prescriber's orders, dated hat included: e left hand, 4th digit, PRN used to the affected area to				
		acked an individualized apy management plan to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER VIEW ESTATES	1104 4TH	DRESS, CITY, S AVENUE NO BAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01035	include the required CLIENT #5 Client #5 had diagn hypertension and condition in which this inadequate to me Client #5 had preso 2017, for oxygen two device used to delivate a lightweight tube with two prongs that are from which a mixture for the next month a reevaluate. The lice oxygen at two liters prescriber's order. On March 5, 2019, employee D (unlice observed administed Client #5 had oxygen oxygen concentrated Client #5's record la individualized treatment plant that the control of the con	d content noted above. doses that included ongestive heart failure (CHF-a he heart's function as a pump pet the body's needs). driber's orders, dated June 15, to liters per nasal cannula (a per oxygen to a patient through which on one end splits into a placed in the nostrils and the or air and oxygen flow). Use as needed and then ensee was providing the continuous without a at approximately 8:30 a.m., nsed personnel/ULP) was being medications to client #5. In on via nasal cannula. The or was set at 1.5 liters.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 57	01035			
	medications to clier and juice.	nt #10 with thickened water				
	individualized treatr	lacked a developed ment and therapy to include the required content				
	employee A (admin director of nursing) #3, #5 and #10 did therapy manageme required content, as	at approximately 1:30 pm., strator, registered nurse/RN, verified records for clients #2, not contain a treatment and ent plan that included all the nd reported that none of the ould have that information in				
	2018, lacked a writt	plan, dated September 25, ten statement of the treatment that were being provided to				
	as ordered by the p	ving a modified diabetic diet brescriber. Client #3's service vices for assistance with the				
	2017, lacked a writt	e plan, dated September 28, ten statement of the treatment that were being provided to				
	included thickened prescriber. Client #	eiving a modified diet that liquids as ordered by the 10's service plan lacked the nce with the thickened liquids.				

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STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			3) DATE SURVEY COMPLETED	
	-		A. BUILDING:				
		H20675	B. WING		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
01035	Continued From pa	ge 58	01035				
	employee A verified	at approximately 9:00 a.m., I service plans for clients #3 rritten statement of all the re provided.					
	Tasks, Treatments March 5, 2017, note "When a treatment assigned to unlicen authorized Licensee a. Develop and mai treatment or therap	or therapy is delegated or sed personnel, the RN or d Health Professional must: intain a current individualized y management record for dresses the requirements of					
	dated March 5, 201 established after co- initial assessment a reassessment inclua. A description of including nursing an	the home care services, and medication management s and or therapy services, to					
	No further informati	ion was provided.					
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					
01040 SS=F	144A.4793, Subd. 4 Treatments/Therap		01040				
	therapy. Ordered of therapies must be a physician, or other	ation of treatments and represcribed treatments or administered by a nurse, licensed health professional rm the treatment or therapy, or					

H20675 NAME OF PROVIDER OR SUPPLIER VALLEY VIEW ESTATES H20675 STREET ADDRESS, CITY, STATE, ZIP CODE 1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	AND PLAN OF CORRE
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW ESTATES STREET ADDRESS, CITY, STATE, ZIP CODE 1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347	
VALLEY VIEW ESTATES 1104 4TH AVENUE NORTHEAST LONG PRAIRIE, MN 56347	NAME OF PROVIDER
LONG PRAIRIE, MN 56347	
OVALID CLIMMADY CTATEMENT OF DEFICIENCIFC 15 DOCUMENTO DI AN OF CODDECTION 11-	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
may be delegated or assigned to unlicensed personnel by the licenseed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record, and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for treatment services for two of two clients (#10, #3) with records reviewed; and to train and determine competency to perform the treatment services for one of one employee (D) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	may be personal according for delegate the hone register profess (1) instruction (2) specific each classification (3) compabout the client (3) com

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE COMP	SURVEY LETED
71142 1 27114			A. BUILDING:		OOWII	LLTLD
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
0(0.15	CLIMMADV CTA		AIRIE, MN 5		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01040 Continued From page 60		01040				
		cted or has potential to affect ll of the clients). The findings				
	INSTRUCTIONS CLIENT #10 Client #10's record instructions for trea powder used to thic	lacked written, specific tment services of thick-it (a cken liquids for clients with es) administered by nel (ULP).				
		noses that included benign ny (BPH) with urinary retention				
		scriber's orders, dated January ded "thicken liquids".				
	employee D (ULP)	at approximately 8:45 a.m., was observed to administer nt #10 with thickened water				
		lacked specific written If for the use of thickened				
	CLIENT #3 Client #3's record la instructions for ULF	acked written, specific of for a diabetic diet.				
	Client #3 had diagn diabetes mellitus, a	oses that included dementia, nd gouty arthritis.				
	Client #3 had preso 2017, that included	riber's orders, dated May 8, a diabetic diet.				

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Client #3's record lacked specific written

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	172010
VALLEY	VIEW ESTATES		AVENUE NO			
	ı		AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
01040	Continued From pa	ge 61	01040			
	instructions for ULF diet.	regarding the client's diabetic				
	provide treatment s	oyee record lacked				
	On March 5, 2019, at approximately 8:50 a.m., employee D reported she was unaware of specific written instructions for the administration of thickened liquids for client #10, or a diabetic diet for client #3, and had not received training and competency testing regarding thickened liquids.					
	employee A (admin nursing) verified the instructions for thick	at approximately 9:30 a.m., istrator, RN, director of ere were no specific written kened liquids or a diabetic diet ensee's staff had been trained ned liquids.				
	Tasks, Treatments March 5, 2017, note "When a treatment assigned to unlicen authorized Licensee "b. Instruct the unlic methods to provide task with respect to that the unlicensed the ability to compe	cy "Delegation of Nursing or Therapy Tasks" dated ed: or therapy is delegated or sed personnel, the RN or d Health Professional must:" censed personnel in the proper the treatment or perform the each client and determine personnel have demonstrated tently follow procedures; instructions for each client and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01040	document those instand d. Communicated vabout the individual	with the unlicensed personnel needs of the client."	01040			
01045 SS=D	days 144A.4793, Subd. 5 Treatment/Therapy Subd. 5. Document	5 Documentation of administration of	01045			
	therapy administered care provider must record. The docume signature and title cadministered the treinclude the date and treatment or therap ordered or prescrib document the reason	eatment or therapy and must d time of administration. When ies are not administered as ed, the provider must on why it was not administered rocedures that were provided				
	by: Based on observati review, the licensee documentation of a and therapies that v	ent is not met as evidenced on, interview, and record e lacked evidence of dministration of treatments were provided to meet the 70 of four clients (#3 and #10) ed.				
	violation that did no	ed in a level two violation (a t harm a client's health or potential to have harmed a				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01045	client's health or sa cause serious injury was issued at an islimited number of climited number of situation has occurrindings include: FAILURE TO DOCI PROVIDED Records for clients treatments and their prescribed, or to do were not administed procedures that we client's needs. CLIENT #3 Client #3 had diagn diabetes mellitus ar Client #3 had prescent administration of a compart of the compart	fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The JMENT TREATMENTS #3 and #10 lacked evidence rapies were administered as ocument the reason why they red, and any follow-up re provided to meet the oses that included dementia, and gouty arthritis. In the provided to meet the diabetic diet. acked documentation of the diabetic diet. at approximately 8:05 a.m., ansed personnel/ULP) was client #3 with breakfast. employee A (administrator, N, director of nursing) instration of treatments would the "Service Recap	01045			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED	
71101 1511	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01045	Continued From pa	ge 64	01045			
	employee A verified	at approximately 9:00 a.m., I the lack of documentation yided the diabetic diet for client be prescriber.				
		noses that included benign ny (BPH) with urinary retention				
	Client #10 had prescriber's orders, dated January 11, 2019, that included "thicken liquids".					
	Client #10's record administration of th	lacked documentation of the e thickened liquids.				
	employee D (ULP)	at approximately 8:45 a.m., was observed administering nt #10 with thickened water				
	administration of tre	employee A indicated the eatments would be "Service Recap Summary".				
		reflected staff had provided s during the months of				
	employee A verified indicating staff prov	at approximately 9:00 a.m., I the lack of documentation yided the thickened liquids for ed by the prescriber.				
		ot provide a policy regarding of treatments and therapies.				

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No further information was provided.

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01045	Continued From page 65		01045			
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01050 SS=D	144A.4793, Subd. 6	6 Orders or Prescriptions	01050			
	Subd. 6. Orders or prescriptions. There must be an up-to-date written or electronically recorded order or prescription for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency and other information needed to administer the treatment or therapy.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to obtain current and accurate prescriptions for oxygen therapy administration for one of one client (#5) with record reviewed.					
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an is limited number of c limited number of s	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The				
		rrent, accurate prescriber's herapy administration.				
	Client #5 had diagn	oses that included ongestive heart failure (CHF-a				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 33/3	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
VALLEY	VIEW ESTATES		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
01050	Continued From pa	ge 66	01050	DEI IOIENOT)		
	condition in which the	he heart's function as a pump eet the body's needs).				
	2017, for "oxygen 2 device used to deliv a lightweight tube w two prongs that are	riber's orders, dated June 15, liters per nasal cannula [a ver oxygen to a patient through which on one end splits into placed in the nostrils and re of air and oxygen flow]. Use as needed and then				
	employee D (unlice observed administed Client #5 was received annula. Employee #5 to the lobby earloxygen concentrated would transfer the cotank later. The oxygen, employee I two liters continuou two liters, and repobumped or somethic	at approximately 8:30 a.m., nsed personnel/ULP) was bring medications to client #5. Wing oxygen via a nasal D said she had assisted client iter and just brought the perfor the time being, and oxygen tubing to an oxygen gen concentrator was set at keed about the liter flow of the D verified it should be set at s, employee set the oxygen to red it must have been ang. Client #5's record lacked for continuous oxygen at two currently receiving.				
	employee A (admin director of nursing) should be set at two verified the licensed prescriber's orders	at approximately 3:00 p.m., istrator, registered nurse/RN, verified client #5's oxygen o liters continuously, and also e had not obtained written for the continuous oxygen at fter the month trial period.				
		cy, "Content of Medication reatment or Therapy Orders", 7, noted:				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO			
			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
01050	Continued From pa	ge 67	01050			
	signed by the presor the client's nursing "The RN or License assure that the presoription or treat every 12 months, o determined based of No further information	ed Health Professional will scriber renews a medication ment or therapy order at least r more frequently if on the nursing assessment."				
01080 SS=D	144A.4794, Subd. 3	3 Contents of Client Record	01080			
00-D						
	Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
VALLEY	VALLEY VIEW ESTATES			PRTHEAST		
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	AIRIE, MN 5	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
01080	Continued From pa	ige 68	01080			
	(8) documentation of client's status and at the needs of the client appropriate superviprofessional; (9) documentation and actions taken in client including reposupervisor or health (10) documentation provided as identific (11) documentation and reviewed the h (12) documentation provided the staten limitations of services under section (13) documentation resolution; (14) discharge sum termination notice a when applicable; and (15) other documentation chapter and relevant status. This MN Requirements when the client provider (speech tocommunications per communications per comm	of significant changes in the actions taken in response to including reporting to the				

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This practice resulted in a level two violation (a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO BAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01080	violation that did no safety but had the policient's health or sa cause serious injury was issued at an is limited number of colimited number of situation has occur findings include: Client #10's record documentation of high the speech therapy Client #10 had diag prostatic hypertrople Client #10's record dated January 11, 2 to be completed by record lacked any a regarding speech the evaluation having be completed by record lacked any a regarding speech the evaluation having be consulted in the contain documents or any committee the contain documents or an	It harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and clients are affected or one or a lients are affected or one or a taff are involved or the red only occasionally). The failed to include ealth information regarding provider and services. Inoses that included benign my (BPH) and dementia. Included a prescriber's order, 2019, for a swallow evaluation speech therapy. The client's additional documentation merapy or the swallow een provided. at approximately 9:00 a.m., istrator, registered nurse/RN, verified client #10's record didentation of swallow evaluation munication with the speech by, "Content of Client arch 5, 2017, noted: will contain:" on including: sis and any other relevant	01080			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		H20675	B. WING		03/0	7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
01080	Continued From pa	ge 70	01080			
	managing; and v. Other relevant "f. All records of collent's home care s No further information	mmunications pertinent to the services."				
01155	01155 144A.4795, Subd. 7(d) RN/LHP Responsibilities		01155			
01155 SS=F	(d) When the regist professional delegathat prior to the delegati trained in the propertasks or procedures for each demonstrate the abprocedures and perform the tashas not regularly percare task for a period of unlicensed personn competency in the fappropriate license registered nurse or must document instasks in the client's This MN Requirements.	ered nurse or licensed health tes tasks, they must ensure on the unlicensed personnel is a methods to perform the client and are able to sility to competently follow the exts. If an unlicensed personnel erformed the delegated home 24 consecutive months, the sel must demonstrate task to the registered nurse or disconsecutive months. The licensed health professional. The licensed health professional tructions for the delegated record.	01135			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
		H20675	B. WING		03/07/2019		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	, 55/6		
	VIEW ESTATES		AVENUE NO				
LONG PF			AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01155	Continued From pa	ge 71	01155				
	reviewed.						
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when asive or represent a systemic cted or has potential to affect II of the clients). The findings					
	Employee records for employees E and D lacked documentation the RN had trained and determined competency for the use of bed and chair alarms prior to the employees performing the delegated tasks. In addition, the employee record for employee D lacked documentation the RN had trained and determined competency for the employee to use a wrist blood pressure cuff.						
	BED AND CHAIR A EMPLOYEE E Employee E (unlice hire date of August	nsed personnel/ULP) had a					
	a.m., employee E w client #2 who used staff when the clien bed or chair without reported she had no	between 6:55 a.m. and 7:25 was observed working with bed and chair alarms to alert t attempted getting out of the t staff assist. Employee E ot received training from the se of the bed and chair					
	EMPLOYEE D Employee D (ULP) 2016.	had a hire date of February 8,					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
01155	Continued From pa	ge 72	01155			
	a.m., employee D v clients #4 and #8 w to alert staff when t the bed or chair wit reported she had no RN regarding the u alarms.	between 7:25 a.m. and 9:00 was observed working with ho used bed and chair alarms hey attempted getting out of hout staff assist. Employee Dot received training from the se of the bed and chair				
	WRIST BLOOD PRESSURE CUFF EMPLOYEE D On March 5, 2019, at approximately 7:40 a.m., employee D was observed checking client #4's blood pressure with an automatic wrist blood pressure cuff. Employee D reported she had not received specific training by the RN regarding the use of the wrist blood pressure cuff.					
	On March 6, 2019, at approximately 10:30 a.m., employee A (administrator, RN, director of nursing) verified that employee records for employees D and E lacked documentation of training and competency evaluations by the RN, prior to providing the delegated tasks, for the use of the bed and chair alarms, and the wrist blood pressure cuff.					
	had not provided tra evaluations for any	ee A verified that the licensee aining and competency ULP regarding the use of bed nd the wrist blood pressure				
	Evaluation of Unlice 2017, noted: "Unlicensed home orientation and train determined to be co	cy "Valley and Competency ensed Staff", dated March 5, care personnel will meet all ning requirements and will be competent to perform all the RN or other Licensed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
71101 1511	or contribution	BENTI IOMION NOMBER.	A. BUILDING:		CONT	LLILD
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VALLEY VIEW ESTATES 1104 4T LONG F			PRTHEAST 66347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01155	Continued From pa	age 73	01155			
		I, when appropriate, before nel may provide any service to				
	The policy lacked information regarding whether the unlicensed personnel were able to competently follow the procedures and perform the tasks.					
	No further information was provided. TIME PERIOD FOR CORRECTION: 21 days					
01170 SS=D	144A.4796, Subd. 2	2 Content of Orientation	01170			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
0(0.15	CLIMMADV CTA		AIRIE, MN 5		ON!	()(5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01170	Continued From pa	ge 74	01170			
	Services, county mother relevant advo (8) review of the type employee will be proceeded to be proceeded to the corientation may also services to clients who is to be high quality include online training on one or more of the corientation of the corientation of the corientation on the corientation of the corientation on the corientation of the corientation, and depression of the corientation of the corie	anaged care advocates, or cacy services; and bes of home care services the oviding and the provider's etopics listed in paragraph (a), or contain training on providing with hearing loss. Any training wided under this subdivision y and research-based, maying, and must include training the following topics: of age-related hearing loss is itself, its prevalence, and to communication; elated to untreated loss, such as increased tria, falls, hospitalizations, ession; or cut strategies and technology				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to home care regulations and requirements included the required content for one of one employee (A) providing services to clients with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
			7. BOILDING.				
		H20675	B. WING		03/0	07/2019	
NAME OF PROVIDE	R OR SUPPLIER			STATE, ZIP CODE			
VALLEY VIEW E	STATES		AVENUE NO AIRIE, MN 5				
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
safety client's cause was is limited situati finding Employer and a revider home includ -an over 144Acomposition and a revider on Market and composition and a revider situation of the situat	s health or sa serious injur sued at an is I number of of I number of so In number of so on has occur gs include: byee A (admir or of nursing) y 20, 2014. ew of employ nce the employ care regulatived: rerview of the 4798; diance with an extment of mi sections 626 ling of clients aints, and white ing information y Complaints arch 6, 2019, yee A verified attion at the till regarding ar ng of clients' extment.	potential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The histrator, registered nurse/RN, was employed by the licensee see A's employee record lacked by the licensee one and requirements that sections 144A.43 to and reporting of the nors or vulnerable adults 1.556 and 626.557; and 1.556 and 626.	01170				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
ANDILAN	OF GOTHLOTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD	
		H20675	B. WING		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO				
	I		AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01170	Continued From pa	ge 76	01170				
	orientation to home providing home car "At minimum, this of following topics: a. An overview of M Statutes 144A.43 to "f. Our program's syresponding to compaints and information of the contact these agen." No further informations	care requirements before e services to clients." brientation must include the dinnesota's home care law (MA o 144A.4798);" system for receiving and colaints, where to report formation on the Office of eplaints and the Common of clients, staff and others may cies with complaints;"					
01190 SS=D	Subd. 6.Required a (a) All staff that per services must compannual training for e employment. The treather the home care proving include topics home care services include: (1) training on reporting minors under section of vulnerable adults whichever is applicated (2) review of the home and implestandards including	form direct home care plete at least eight hours of	01190				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
	PROVIDER OR SUPPLIER	1104 4TH	DRESS, CITY, ST AVENUE NOF BAIRIE, MN 56	RTHEAST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01190	gloves, gowns, and of contaminated mas dressings, needle blades; disinfecting disinfecting environ reporting of commu (4) review of the proprocedures relating services and how to procedures. (b) In addition to the annual training may providing services to Any training on heast subdivision must be research-based, manust include training following topics: (1) an explanation cand how it manifest challenges it poses. (2) health impacts rage-related hearing incidence of demensionation, and depresionation, and depresionation, included assistive listening dand tactile alerting of and tactile alerting of the provided assistive and tactile alerting of the provided and tactile alerting of the provided assistive and tactile alerting of the provided and ta	masks; appropriate disposal aterials and equipment, such es, syringes, and razor reusable equipment; mental surfaces; and unicable diseases; and ovider's policies and to the provision of home care of implement those policies and et topics listed in paragraph (a), a also contain training on of clients with hearing loss. Fing loss provided under this en high quality and any include online training, and go none or more of the of age-related hearing loss is itself, its prevalence, and to communication; elated to untreated loss, such as increased that, falls, hospitalizations, ession; or ut strategies and technology				
	Based on interview licensee failed to er direct home care se	ot met as evidenced by: and record review, the asure all staff who perform ervices completed the required al training for each 12 months				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01190	records reviewed. This practice resulte violation that did no safety but had the policine client's health or sacause serious injury was issued at an iselimited number of climited number of sistuation has occurrifindings include: Employee D (unlice hire date of Februar Employee D's employe	one of two employees (D) with one of two employees (D) with ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to an interest of the potential to have harmed a fety, but was not likely to an interest of the potential to have harmed a fety, but was not likely to an interest of the potential training of the potential training for the potential training for 2017 and the following required content: the following required content: the following required content: the potential training for 2017 and the following required content: the following required content is the following r	01190			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION	DNI .	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
01190	Continued From page 79		01190			
	employee A (administrator, registered nurse/RN, director of nursing) verified employee D lacked the required annual training.					
	Training," dated Ma "1. All staff that periservices, including at least eight hours months of employm 2. The annual traini direct home care sea. Training on report under section 626.5 vulnerable adults utwhichever is applicable our agency [Chaagency's clientele.] b. Review of the Hoc. Review of Infection home and impleme standards, including i. A review of hand ii. The need for and gowns, and masks; iii. Appropriate disp	forms direct home care licensed staff, must complete of annual training for each 12 ment. Ing for all staff performing ervices must include: ting of maltreatment of minors 556 and maltreatment of nder section 626.557, able to the services provided inge this as appropriate to your of the control techniques in the intation of infection control g: washing techniques; use of protective gloves, osal of contaminated materials thas dressings, needles,				
	vi. Reporting of con "f. Review of our ag procedures related services."	ronmental surfaces; and nmunicable diseases." lency's policies and to the provision of home care				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO			
(V4) ID	SHIMMARY STA	TEMENT OF DEFICIENCIES	AIRIE, MN 5	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01225	Continued From pa	ontinued From page 80				
01225 SS=D	144A.4797, Subd. 3 Supervision of Staff - Comp		01225			
	nursing or therapy I who perform delegal care tasks must be licensed health properiodically where the provided to verify the performed competer and solutions related to perform the tasks performing medical administration shall nurse or appropriate and must include observing the performing medical administration shall nurse or appropriate and must include observing the performing medical and must include observing the performance of the performanc	be provided by a registered e licensed health professional				
	 (b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days after the individual began working for one of one employee (E) with record reviewed. 					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		I AVENUE NO RAIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01225	This practice resulte violation that did no safety but had the pclient's health or sa cause serious injury was issued at an ise limited number of climited number of situation has occurr findings include: Employee E (unlice providing services f 2018. Employee E was obtasks during the sure Employee performin days after the individuals after the perioded: "Direct supervision delegated nursing the agency and has been accomplished after the perioded after and the perioded after the perioded after and the perioded after the perioded after and the perioded after a	ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to a fety one or a dients are affected or one or a fet are involved or the end only occasionally). The fety one of the licensee on August 17, and the licensee of the fety process. The licensee on August 17, and the license of the license of the license of the licensee of the	01225			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
71110 1 27111	or connection	BENTH TO ATTOMBET.	A. BUILDING:		001111		
		H20675	B. WING		03/0	7/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO				
			AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01225	Continued From page 82		01225				
	TIME PERIOD FOR CORRECTION: Twenty one (21) days						
01245 SS=F	144A.4798, Subd. ⁻	TB Prevention and Control	01245				
	control. A home car and maintain a TB program based on issued by the Centers for Disease (CDC). Component control program include screening a services, both paid for active TB disease a developing and imp infection control plan. The co- most recent CDC s care	erculosis (TB) prevention and re provider must establish prevention and control the most current guidelines. The Control and Prevention and all staff providing home care and unpaid, at the time of hire and latent TB infection, and plementing a written TB tandards available to home partment's Web site.					
	by: Based on interview licensee failed to estuberculosis (TB) pubased on the most the Centers for Disc (CDC) which including implementing a TB included procedure active TB disease.	and record review, the stablish and maintain a revention and control program current guidelines issued by ease Control and Prevention led developing and infection and control plan that is for handling persons with					

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		H20675	B. WING		03/0	7/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
	safety but had the polient's health or sacuse serious injury was issued at a wide problems are pervafailure that has affe a large portion or al include: During the entrance 2019, at approxima (administrator, registance) provided the Assessment, dated control plan titled "I dated March 5, 201 indicated the licens Employee A verified was not completed handling persons where the months of the Minnesota Deputing and based or TB infection control was not limited to, where the months of the Minnesota Deputing in Minnesota Health 2013, and based or TB infection control was not limited to, where the months of the Minnesota Deputing in Minnesota Health 2013, and based or TB infection control was not limited to, where the months is procedured to include and referral for personal transfer of the months of the mo	t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings a conference, on March 4, tely 9:10 a.m., employee A stered nurse/RN, director of the licensee's TB Risk March 28, 2018, and infection TB Prevention and Control", 7. The risk assessment ee was at "low risk." If the TB infection control plan to include procedures for include procedures for ith active TB disease. Deartment of Health (MDH) tions for Tuberculosis Control on Care Settings", dated July on CDC guidelines, indicated a program should include, but written TB infection control de early recognition, isolation, sons with suspected TB.	01245				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2010
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/0	7/2019
			AVENUE NO	•		
VALLEY VIEW ESTATES LONG PF			AIRIE, MN 5	6347		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01245	Continued From page 84		01245			
	immediately;"					
	The policy failed to actions" would be.	indicate what the "appropriate				
	No further informat	ion was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One				
02025 SS=D	626.557, Subd. 4 R	eporting	02025			
	Subd. 4.Reporting.					
	mandated reporter oral report to the contelecommunication similar device shall. The common entry reports. To the extended be of sufficient contadult, the caregiver suspected maltreatment previous maltreatment the reporter, the timincident, and any or reporter believes must be suspected maltreporter may disclosin section 13.02, ar sections 144.291 to necessary to composite to the communication of the communication in section 13.02, ar sections 144.291 to necessary to composite the communication of the communi	ded in paragraph (b), a shall immediately make an ammon entry point. Use of a selection device for the deaf or other be considered an oral report. point may not require written ent possible, the report must tent to identify the vulnerable, the nature and extent of the ment, any evidence of ent, the name and address of the date, and location of the ther information that the light be helpful in investigating reatment. A mandated se not public data, as defined and medical records under 144.298, to the extent by with this subdivision.				
	sections 144.50 to Title 19 of the Socia	home that is licensed under 144.58 and certified under al Security Act, a nursing home er section 144A.02 and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
02025	certified under Title Security Act, or a his sections 144.50 to certified under Cod 42, section 482.66, electronically to the of submitting an oraduplicate of the initial electronically to the comply with the rep Code of Federal Ref 483.13. The commithese reporting required under para	age 85 18 or Title 19 of the Social ospital that is licensed under 144.58 and has swing beds to of Federal Regulations, title may submit a report common entry point instead al report. The report may be a dial report the facility submits commissioner of health to corting requirements under regulations, title 42, section issioner of health may modify uirements to include items agraph (a) that are not in the electronic reporting form.	02025			
	by: Based on interview licensee failed to in origin to determine the Minnesota Adul (MAARC) for one orinjuries with record. This practice result violation that did not safety but had the process client's health or sa cause serious injur was issued at an is	ent is not met as evidenced and record review, the evestigate injuries of unknown if they should be reported to it Abuse Reporting Center of one client (#3) who sustained reviewed. ed in a level two violation (a bit harm a client's health or cotential to have harmed a effety, but was not likely to y, impairment, or death), and olated scope (when one or a elients are affected or one or a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20675	B. WING		03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5	_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02025	limited number of sistuation has occurr findings include: Client #3 sustained hand, and right hip, evidence of an invesource of the unknown should be made to CLIENT #3 Client #3 had diagn arthritis, diabetes midicated services the safety checks, behave reminders, medicated medication setup. Client #3's "Clinical December 17, 2018 assessment) noted abused, could be vesometimes rude to was disoriented occurrent was disoriented occurrent at 8:01 a.m., noted with a skin tear on the same day, emp noted on the same and fingers were breat swollen, and a larged The record indicated January 26, 2019, a hurt it getting out of witnessed.	taff are involved or the red only occasionally). The injuries to the left arm, left and the licensee lacked stigation to determine the own injuries and if a report MAARC. oses that included gouty nellitus, and dementia. Client dated September 25, 2018, o include daily wellness and avior management, dressing ion administration, and Update Summary", dated 3, (the most recent the client was at risk to be erbally abusive at times, was staff and other residents, and,				
		loyee A (administrator, RN,				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		1100075	B. WING		00/0	7/0040
		H20675			03/0	7/2019
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S AVENUE NC	STATE, ZIP CODE		
VALLEY VIEW ESTATES			AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
02025	Continued From pa	ge 87	02025			
	director of nursing) hand being very sw newly developing lo have him seen in the assessment and to condition that could. The client's record evidence an investite RN to determine how the left hand injury, occurred. In addition the injuries of unknown to MAARC. On March 5, 2019, employee A (admin nursing) was intervising incensee had not do injuries sustained by whether the injuries.	noted "At this point with his collen, increase in falls, and cose incontinent stools, we will be clinic today for further rule out an underlying be a contributing factor." Itacked documentation to gation was conducted by the low the skin tear to the left arm, and bruising to the right hip in, the record lacked evidence own origin had been reported at approximately 1:30 a.m., istrator, RN, director of lewed and reported the one an investigation of the y client #3 to determine is were unexplained and rould be filed with MAARC.				
	Employee A confirm	ned the unwitnessed injuries of reported to MAARC.				
	client #3 was intervabove. Client #3 reput doesn't recall hoobtained any of the on his body. It was much of the intervieunknown if the word	at approximately 11:00 a.m., iewed regarding the incident corted he "falls many times", by he hurt his hand or other bruises and abrasions difficult to determine how was reliable since it was de he was saying were what due to his word-finding ntia.				
	Investigation Policy "Agency staff is req	nerable Adult Reporting and ", dated March 5, 2017, noted, uired to report to the CEP nt] when a client has sustained				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		H20675	B. WING		03/0	7/2019
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
VALLEY	VIEW ESTATES		AVENUE NO AIRIE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
02025	a physical injury whexplained. Such physical ingury whexplained. Such physical ingury whexplained physical the RN [or home can internal investigatermine whether whether a report to the addition, the policity based on the witness whether maltreatmed conjunction with the immediately begin in within 24 hours followed the cases of unexplained maltreatment were the conjunction with the immediately begin in within 24 hours followed the cases of unexplained maltreatment were the cases of unexplained	ich is not reasonably ysical injuries may include, but nexplained bruises, skin tears, ures. Staff that observes an al injury will immediately notify are director], who will conduct ation, as described below, to the injury is unexplained and the CEP is required." by indicated "If it is unclear as account of the incident ent has occurred, the RN, in the home care director, will envestigating the incident. If the powing the initial report, the RN are reportable maltreatment and the CEP." The licensee eit policy to ensure that all the injury or suspected reported.	02025			