STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165353	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vue Care Center	108 Second Ave Armstrong, IA 50514

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review, manufacturer's guidelines and staff interview, the facility failed to assure residents insulin pen was primed prior to insulin administration preventing a significant medication error for 1 of 1 resident reviewed (Resident #12). The facility reported a census of 32 residents.Findings include:During an ongoing observation on 3/11/2026 starting at 11:04 a.m., of Staff A, Registered Nurse (RN) preparing to check Resident #12's blood sugar prior to meal and administer insulin. Staff A checked the insulin orders and did not perform hand hygiene prior to applying gloves. Staff A removed the insulin pen from the medication cart and an insulin pen needle. Staff A turned the dial to 2 units without the insulin pen needle on it and pushed the trigger. Staff A with the soiled gloves still on applied the insulin pen needle and turned the dial to 10 units. Staff A was unsure of which side she was to administer the insulin and left the room with the soiled gloves on. Staff A reentered the room with gloves on and moved the shirt up, and pulled the edge of the residents brief down to expose the abdomen and with the gloves still on opened an alcohol swab, administered the insulin, pulled shirt back down, took glove off, did not perform hand hygiene and discarded the insulin pen needle and performed hand hygiene. Review of the manufacturer's guidelines for administering insulin injection with the Flexpen with a revision date of 2/2023 revealed the following under giving an airshot before each injection:Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injection air and to ensure proper dosing Turn the dose selector to select 2 unitsHold your FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make sure any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way. The dose selector returns to 0. A drop of insulin should appear at the need tip. If not, change the needle and repeat the procedure no more than 6 times. Interview on 3/11/2026 at 12:44 p.m., with the Director of Nursing (DON) revealed she would expect the staff to prime the insulin pen with the needle prior to administration.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, infection control policy and staff interview, the facility failed perform proper hand hygiene and adhere to infection control guidelines during medication pass for 1 of 4 residents observed (Resident #12) The facility reported a total census of 32 residents.Findings include: During an ongoing observation on 3/11/2026 starting at 11:04 a.m., of Staff A, Registered Nurse (RN) preparing to check Resident #12's blood sugar prior to meal. Staff A removed items needed for blood sugar check. Staff A without performing hand hygiene applied gloves. With gloves on locked the medication cart, knocked on the residents door, opened the door to the residents room, picked up the barrier and placed the barrier onto the bed and placed supplies on the barrier. Staff A with soiled gloves opened an alcohol swab and cleaned the area on the resident's finger, with soiled gloves still on and used the glucose monitor to check the resident's blood sugar. With the soiled gloves on Staff A cleaned up her supplies and barrier and removed one glove. Staff did not perform hand hygiene. Staff A opened the medication cart and retrieved the sanitizing wipes and wiped off the glucose monitor and placed back into the supplies and placed into the medication cart. Staff removed the second soiled glove and without performing hand hygiene put gloves back on and used a sanitizing wipe and wiped off the medication cart off, placed the wipes back into the drawer, removed gloves and performed hand hygiene. Staff A checked the insulin orders and did not perform hand hygiene prior to applying gloves. Staff A removed the insulin from the medication cart and an insulin pen needle. Staff A turned the dial to 2 units without the insulin pen needle on it and pushed the trigger. Staff A with the soiled gloves still on applied the insulin pen needle and turned the dial to 10 units. Staff A with gloves still on used the computer mouse, knocked on the residents door, opened the door, lifted the residents shirt. Staff A was unsure of which side she was to administer the insulin and left the room with the soiled gloves on. Staff A reentered the room with gloves on and moved the shirt up, and pulled the edge of the residents brief down to expose the abdomen and with the gloves still on opened an alcohol swab, administered the insulin, pulled shirt back down, took glove off, did not perform hand hygiene and discarded the insulin pen needle and performed hand hygiene. Review of facility provided policy titled Hand Hygiene with a revision date of 10/2023 revealed hand Hygiene using alcohol-based hand rub is recommended during the following situations (not limited to the following):before and after direct resident contactafter contact with blood, body fluids or surfaces contaminated with blood and body fluidsAfter removing gloves including during wound dressing change Interview on 3/11/2026 at 12:44 p.m., with the Director of Nursing (DON) revealed she would expect the staff to be sure to keep the clean and dirty separate when using gloves.