

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/29/2024
NAME OF PROVIDER OR SUPPLIER  Valley View Manor Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  200 East Ninth Avenue Lamberton, MN 56152	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>39998</p> <p>Based on interview and document review, the facility failed to ensure residents had access to their personal funds upon request for 1 of 1 resident (R5) reviewed. This had the potential to effect 14 residents who utilized a personal funds account.</p> <p>Findings include:</p> <p>During an interview on 3/28/24 at 10:19 a.m., R5 stated she was able to access her money only when administration or the business office was open. She could not access her personal funds on weekends or holidays.</p> <p>During an interview on 3/28/24 at 2:00p.m., licensed practical nurse (LPN)-A indicated if a resident wants funds they have to go to the administrator or the business office manager during business hours.</p> <p>During an interview and observation on 3/28/24 at 2:26 p.m., the administrator indicated residents do have access to their money after hours and thought there was \$30.00 in the medication room in a cash box if a resident requested money. Further indicated all staff should know how to access it. The administrator requested the assistance of LPN-A to gain access to the medication room holding the cash box but had difficulty locating the cash box and the key to open the box. After 5-10 minutes, the keys were located and the cash box was opened to reveal \$45.00 cash in the box with the last noted withdrawal of \$5.00 on 3/3/2020. LPN-A stated she did not know the cash box was there.</p> <p>During an interview on 3/28/24 at 4:00 p.m., the assistant director of nursing (ADON) stated the residents only had access to their funds when the administrator or the business office manager were in the facility. ADON indicated she was unaware of any money in the medication room for resident use or how to access it.</p> <p>The facility's policy titled, Deposit of Resident Funds last updated 8/15/23, indicates resident requests for access to their funds should be honored by facility staff as soon as possible but no later than the same day for amounts less than one hundred \$100 (\$50 for Medicaid residents) and three banking days for amounts of \$100 (\$50 for Medicaid residents) or more.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34083</p> <p>Based on interview and document review the facility failed to provide required timely notifications for 1 of 2 residents ( R4) who experienced falls.</p> <p>Findings include:</p> <p>R4's 3/17/24 Significant change Minimum Data Set (MDS) assessment identified she was on hospice services (3/7/24), her cognition was intact, and she required supervision and assistance with her Activities of Daily Living (ADLs). R4 had diagnoses of dementia, malnutrition, history of falls and urinary incontinence.</p> <p>R4 experienced 3 documented falls in the month March and family members expressed their concern regarding supervision and factors contributing to her falls.</p> <p>1.) 3/11/24 at 1:45 p.m. R4 was found lying on the floor in her room with her walker next to her. Blood was noted on the floor and she had a large lump and a laceration on the back of her head. Additional minor injuries included skin tears on her left hand, right forearm, and ankle. R4's record indicated the family was notified.</p> <p>2.) 3/20/24 at 5:00 p.m. R4 was walking in the hall with her walker and had a gait belt around her waist. An unidentified staff person was walking behind R4 with no contact on resident's gait belt. The report identified the walker got ahead of her, she lost her balance and fell forward landing on her knees and obtained a moon shaped cut on her left knee. There was no documentation on either the report or resident record of notification of the director of nursing (DON).</p> <p>3.) 3/21/24 at 5:55 p.m. R4 was discovered lying on the floor in front of her chair with a large hematoma (bruise) noted on the left side of her forehead above her left eye, below the hair line. Further assessment identified a small skin tear on her left elbow. There was no documentation on either the Incident report or resident record of notification of the responsible party or family members.</p> <p>Interview on 3/27/24 at 1:54 p.m., during R4's care conference with multiple family members and the hospice registered nurse (RN) identified R4 had been a resident at the facility since March of 2021. FM-A with agreement from other FM's in attendance reported they had not had concerns with R4's care and safety until the past month when she experienced 3 falls. Family member (FM)-A (designated for notification) reported she was not notified by the facility and was not aware of R4's fall on 3/21/24. FM-A reported her concern with not receiving notification, especially with the amount of facial injury and questioned if there were additional incidents she had not been notified about. She reported R4 would not remember what had happened and the family had depended on the facility to take care of their family member and notify them if there were any areas of concern.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/27/24 at 3:43 p.m., with the director of nursing (DON) reported her expectation for all licensed staff to follow the facility policy for assessment and appropriate notification of the DON, medical provider, and family as soon as possible following an incident. She reported if a fall with no injury occurred during the night and family requested to wait until morning to be notified, that was acceptable. In the instance of R4's fall on 3/21/24 at 5:45 p.m., the family should have been notified once the assessment was completed to determine if they wanted R4 sent to the Emergency department for further evaluation. She also reported staff should have notified her following R4's fall on 3/20/24 and would need to investigate further.</p> <p>Review of the October 4, 2021 Falls-Clinical Protocol Steps in the Procedure identified to evaluate for possible injuries, monitor vital signs, position the resident comfortably if no injury, and document relevant details. Notify the resident's attending physician and family in an appropriate time frame. Documentation recorded in the medical record was to include details of the fall, assessment data, any interventions implemented, notification of physician and family and signature and title of the person recording the data.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>34083</p> <p>Based on interview and document review the facility failed to ensure all staff working in the dietary department had training on use of equipment, safe temperatures to ensure food safety and sanitation processes. This had the potential to affect all 23 residents in the facility.</p> <p>Findings include:</p> <p>Entrance conference on 3/27/24 at 9:15 a.m. with the director of nursing (DON) and administrator identified the facility was having issues with staffing in the dietary department and multiple staff were assisting with meal preparation and clean up. Both the DON and administrator reported they had assisted in the dietary department. The administrator reported she had worked as a dietary aide and assisted with cleanup. The DON reported she had done dishes and assisted with the dining room.</p> <p>Review of the dietary schedule for March 2024 identified 1 trained medication aide (TMA)-A scheduled as PM (evening meal) cook. Review of the January, February and March 2024 dietary schedules identified TMA-A worked 3 shifts in January 2024, 8 shifts in February 2024, and 9 shifts in March 2024 as the evening cook.</p> <p>Observation on 3/27/24 at 5:00 p.m., identified TMA-A in the dietary kitchen as the designated cook for the PM shift. She had worked on the nursing unit for the day shift with resident contact and then worked the PM dietary cook shift. Review of TMA-A's education record identified no specialized orientation to the dietary department, nor was there documentation on the electronic RELIAS education of any courses related to dietary management or food safety.</p> <p>Interview on 3/27/24 at 4:34 p.m., with cook-C reported she was part-time and just filled in because the dietary department was very short of both cooks and dietary aides. She reported due to the lack of dietary staff she had worked with nursing assistants (NA)s who worked on the nursing unit and then helped in the kitchen, but had no training for the kitchen or to work as a dietary aide.</p> <p>Interview on 3/27/24 at 3:47p.m., with the DON reported she had been directed to assist in the dietary department due to lack of staff. She reported she was shown how to run the dishwasher, but had no idea about the temperature requirements, sanitation, or problem solving with the process. The DON reported there had also been nursing assistants who had to help in the kitchen due to staff not showing up, and she was not aware of any specialized training provided.</p> <p>Interview on 3/27/24 at 4:34 p.m. with the assistant dietary manager (ADM) reported the facility had been very short of both dietary aides and cooks over the past few months and she had been helping in dietary as needed. The ADM reported she had ServSafe Certification (program developed by the National Restaurant Association to help set a standard for food safety training in the industry). The ADM reported multiple persons had been assisting in the dietary department including nursing assistants who were not previously trained to work in the dietary department.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 3/28/24 at 3:37 p.m. with the dietary manager (DM) reported when she had taken the position as DM, she had developed an orientation process but had not reviewed to ensure staff working in the department were oriented and/or competent in their assigned duties. The DM identified she had provided some verbal direction to TMA-A but had not completed any documentation, nor was she aware of any orientation provided to additional non dietary staff that had assisted in the department.</p> <p>Observation of the DM on 3/27/24 and 3/28/24 at various times was of her coughing and sneezing while working both in and out of the dietary department. She was observed wearing a mask, which was covering her mouth, but not her nose. When questioned regarding persons working when ill, DM reported she had stayed home when she was ill the previous week but did not have a fever and needed to cover shifts. DM reported she had been asked to be tested for Influenza-A but declined and reported that was what residents and other staff had, so she didn't feel she needed to spend the money to be tested .</p> <p>Interview on 3/29/24 at 12:53 p.m. with the registered dietitian (RD) reported she was aware the facility was having issues with staffing, and had an outbreak of Influenza-A. She reported she came to the facility at least 2 x monthly and had been checking more closely since the outbreak. She reported her expectation for infection control practices to be followed for both staff and residents who had any illness. She also voiced her expectation for orientation/training to be provided to any staff persons who assisted with meal preparation or serving.</p> <p>Review of the January 18, 2022, policy Influenza, Prevention and Control of Seasonal listed Surveillance-when influenza was present in the community or there was one laboratory-confirmed case in the facility, active daily surveillance was to be performed for all new and current residents, healthcare personnel and visitors. Training/Education was to include methods of influenza transmission, signs/symptoms, complications and risk factors for complications, self-assessment and reporting, review of precautions, appropriate use of personal protective equipment (PPE). Staff with acute respiratory symptoms without fever may still have influenza and are evaluated by the infection preventionist to determine appropriateness of contact with residents.</p> <p>Review of the December 9, 2021, policy preventing foodborne illness-food handling identified all employees who handle, prepare, or serve food were to be trained in practices of safe food handling, and prevention of foodborne illness. Employees were to demonstrate both knowledge/competency in practices prior to working with food or serving food to residents.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>34083</p> <p>Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique during 1 of 1 meal service. This had the potential to affect all 23 residents in the facility.</p> <p>Findings include:</p> <p>Observation on 3/29/24 beginning at 11:50 a.m. and extending through the noon meal service identified multiple incidents of potential cross contamination and issues with hand hygiene.</p> <p>Cook-A applied gloves and arranged serving utensils on top of the covered steam table pans. He then picked up tray cards from a table behind the steam table, found the card he was looking for, placed it onto a tray, picked up a plate and using a spatula in his right hand and his left gloved hand, picked up a piece of fish from the steam tray, placed it onto the plate, folded back the foil over the scalloped potatoes, placed a scoop of potatoes onto the plate, used his right gloved hand to push some potatoes back onto the plate from the edge, retrieved a slice of bread from the open bag on the side of the steam table and placed it on top of the plate of food, picked up a cover, placed over the food, went to the side of the serving area picked up a coffee cup, poured coffee from the carafe, returned to the tray, carried the tray into the dining room, where he served the food to a seated resident. (Staff assisting in the dining room were also observed pouring hot water and coffee from the same carafes). He then returned to the steam table to repeat the process. Each time he served a piece of fish, he used the spatula with his right hand, and reached into the steam pan with his left hand to support the piece of fish onto the plate. He repeated this process multiple times, touching plates, trays, tray cards, glasses, cups, and containers of liquids, in addition to pieces of fish and bread with his same gloved hands.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 12:15 p.m. cook-A retrieved a plate of salad and desert from the tray located beside the steam table for an employee, then removed his gloves, washed his hands, and reapplied gloves. He went to the table containing the tray cards, picked up a card, reviewed, picked up a small round bowl containing ground meat, placed it in the microwave, turned the dial to start, waited 20 seconds, removed the bowl and dumped the ground meat onto a plate, using his gloved hand, spread the meat into a flattened shape, when asked about temperature of the meat, cook-A retrieved a thermometer, used his left gloved hand to push the meat into a pile to check the temperature, which was 138 F. He then used his left gloved hand to push the meat back into the bowl and put back into the microwave to reheat. When he took it from the microwave, it had spilled out over the sides of the bowl. Cook-A rechecked the temperature and it was at 160 F. He then dumped it back onto the plate, dished the potatoes and vegetable onto the plate and took to the dining room where he placed it in front of a resident. He returned to the serving area, changed his gloves which were soiled with the ground meat. He picked up a glass from the dish rack of glasses with his gloved right hand, observed a gel like substance on the glass, placed it onto the tray of soiled items, picked up a second glass which was also soiled, disposed of that glass, and retrieved a third from the same rack, which he filled with orange juice and placed on a tray. Without changing his gloves, cook-A retrieved a card and indicated it listed choice of deli meat. He stated he was not certain what this meant and would need to check with ADM. Cook-A carried the card, walked across the hall to the keypad kitchen door, keyed in the code, opened the door and walked into the kitchen. The ADM was not present, so he returned, opened the kitchen door, same gloved hands, returned to the steam table, dished another plate with fish, potatoes, vegetable, and bread, same process touching items with same gloved hands. Served the plate to a resident in the dining room. He then stated he would ask the resident what he meant by Deli meat. Cook-A went over to the resident seated in a wheelchair, placed his right gloved hand on the handle of the wheelchair and resident's back and asked him about his meat choice. With no glove change of hand hygiene, cook-A, again crossed the hall to the kitchen, opened the door via the keypad, entered the kitchen, crossed to the walk-in cooler, which he opened with his gloved hands, entered, and returned with a plastic bag containing slices of precooked, deli style ham. He placed the package of ham on the table in the kitchen, looked around, then picked up the package containing the ham, same gloved hands, opened the kitchen door and exited returning to the steam table where he placed the bag of ham on the front counter of the steam table, opened the package, reached into the package with his left gloved hand and took out several slices of ham which he held in his left gloved hand, picked up a pair of scissors from the cart beside the steam table and cut the ham into pieces, placing them onto a plate. When finished cutting up the meat, he returned the scissors to the cart, placed the package of meat on the cart containing salads for staff meals. Cook-A added potatoes to the plate, filled a glass with juice and a coffee and served the meal to the resident. He then returned to the steam table and continued dishing meals. 12:25 p.m. cook-A continued the same process, but now using his same gloved hands to pick up the fish from the steam table and place onto plates, then dish other foods with scoop, and use hand to place a slice of break on top of the plate. Cook-A took a second bowl of meat and a bowl containing potatoes, heated in the microwave, and checked temperature which was at 130 F. He returned the bowls to the microwave and reheated this time with temperature of 165 F. Used his gloved hands to arrange ground meat on plate, dumped potatoes onto plate, and served to resident in dining room. Cook-A picked up a slice of bread with same gloved hand, retrieved the scissors from the cart and cut off the bread crust before placing the slice of bread on top of the plate of food, which was then served.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>12:50 p.m. cook-A reported everyone had been served. When interviewed he reported he had never been told he needed to check the temperature of pureed or mechanical foods, but just heated and served. When asked how he knew how much food was contained in the bowl of mechanically altered foods, he replied it was the same as what was served on the steam table, but he didn't measure it. The small bowls of food were on the table beside the steam table until they were heated and served. When asked about hand hygiene and glove changes, repeated he should have changed his gloves more frequently, and did not reply when asked about touching food with his gloved hands.</p> <p>Interview at 12:55 p.m. with Cook-A reported he had never been oriented to the kitchen when he started but had worked for a local food service company that had very strict protocols for food safety, so he was comfortable with his job duties.</p> <p>Interview on 3/29/24 at 2:30 p.m. with the DM identified her expectation that dietary staff followed infection control practices with glove changing between tasks, and if they touched a food item. She reported cook-A was employed when she took over in the kitchen and she had not reviewed his training or assessed his competency with food service tasks.</p> <p>Interview on 3/29/24 at 3:50 p.m. with the registered dietitian (RD) identified her expectation for all staff to be trained and follow food safety and hand hygiene guidelines. She reported it was not acceptable to touch food and potentially contaminated services without performing appropriate hand hygiene and glove changes before returning to serving food.</p> <p>Review of the December 9, 2021, policy preventing foodborne illness-food handling identified all employees who handle, prepare, or serve food were to be trained in practices of safe food handling, and prevention of foodborne illness. Employees were to demonstrate both knowledge/competency in practices prior to working with food or serving food to residents.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355</b></p> <p>Based on interview and document review the facility failed to provide adequate and specialized rehabilitative services of occupational therapy (OT) and physical therapy (PT) therapy according to residents individualized needs based on a comprehensive assessment for 2 of 2 residents (R2 and R10) who had orders for physical therapy (PT) and occupational therapy (OT).</p> <p>Findings include:</p> <p>R2's diagnoses included bilateral osteoarthritis, sepsis, pressure wound on buttocks and weakness.</p> <p>R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 was admitted to the facility on [DATE], did not have cognitive impairment, did have impairment to range of motions (ROM) to one upper extremity and both lower extremities, used a walker and wheelchair. R2 was dependent with lower body dressing and putting on/off footwear, personal hygiene and sit to lying position. R2 required maximal assist with toilet hygiene, shower/bathing, rolling side to side in bed, sit to stand position, and transfers. Partial assist with upper body dressing, ambulating 10 feet and wheeling wheelchair 50 feet with two turns. R2 was receiving OT with a start date of 3/7/24, and PT with a start date of 3/11/24.</p> <p>R2's admission physician orders dated 3/5/24, included OT and PT both to eval and treat.</p> <p>R2's Activities of Daily Living (ADL) care plan dated 3/6/24, R1 is extensive assist of one staff for bathing/showering, dressing and toilet use. R2 requires set up for personal and oral hygiene. Independent with bed mobility, with the use of bedrails and trapeze. R2 independent in room per therapy and extensive assist of one staff, front wheeled walker, gait belt and appropriate footwear for ambulation out of room.</p> <p>R2's OT evaluation and plan of treatment dated 3/7/24, ordered a frequency of three to five times per week for eight weeks to improve resident's rehab potential, maximize resident's rehab potential, increase independence with activities of daily living (ADLs), maximize independence with ADL's, and facilitate independence with ADLS in order to enhance resident's quality of life by improving ability to return to prior living situation, certification period of 3/7/24 to 4/5/24.</p> <p>Review of R2's OT notes indicated R2's evaluation was completed on 3/7/24. According to the record R2 was provided services on 3/8/24, 3/11/24, 3/15/24, 3/18/24, 3/20/24, 3/22/24, and 3/25/24. Did not consistently meet the three to five times per week per the ordered treatment plan.</p> <p>R2's PT evaluation indicated R2 was referred to therapy status post hospitalization due to functional decline at home. The plan of treatment dated 3/11/24, directed a frequency of 8 times per period of 4 weeks, intensity of daily with certification period of 3/11/24 to 4/9/24. R2's short term goals included:</p> <p>- Patient will safely perform bed mobility tasks with minimum assist without use of siderails in order to prepare for gait activities (Target 3/24/24). Prior level of function was independent; baseline on 3/11/24 was moderate or modified assist.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Patient will safely perform functional transfers with contact guard assist in order to return to prior level of functional abilities. Prior level of function was independent; baseline on 3/11/24 was minimal assist.</p> <p>-Patient will safely ambulate on level surface 250 feet using FWW with stand by assist with normalized gait patter 100% of the time to increase independence in the facility. Prior level of function was independent; baseline on 3/11/24 was contact guard assist.</p> <p>Review of R2's PT notes identified from 3/11/24 to 3/29/24, R2 received therapy on 3/11/24 and on 3/29/24.</p> <p>-R2's Treatment Encounter Note dated 3/11/24, indicated the session was completed by the physical therapist (PT)-B. The note included Gait training: gait training to normalize patter, PT provided minimal assist during ambulation for patient safety. Patient ambulated 1 x 250 feet, 1 x 100 feet with FWW. Will progress as able. The note did not identify session duration time.</p> <p>-R2's Treatment Encounter Note dated 3/29/24, indicated the session was completed by PT-C. The note included Gait training to improve functional mobility and return patient to previous level of function. Patient ambulated 250 feet with ww (sic) stand by assist with cues for postural alignment and energy conservation techniques. Seated lower extremity exercises in all joints/planes with YTB in order to improve stability during functional ability, forward and backward ambulation to promote ankle strategies and self righting ability. Cues for pacing when ambulating backwards with contact guard assist.</p> <p>All physical therapy notes and evaluations were requested. The requested documentation received from 3/11/24 through 3/29/24 did not include an evaluation of goal status and/or effectiveness of only having physical therapy for two therapy sessions in 18 days.</p> <p>R10's diagnoses included stroke with weakness to one side of his body.</p> <p>R10's admission MDS dated [DATE], indicated an intact cognition, with ROM impairment on one side of his body, used a wheelchair and walker. R10 was dependent with toilet hygiene, lower body dressing, putting on/off footwear. R10 required substantial assist with upper body dressing, personal hygiene, sitting to lying position, all transfers, and walking 10 feet. R10 required moderate assist with oral hygiene, turning side to side in bed, and lying to sitting position. R10 was independent with wheeling 50 feet with two turns and wheeling 150 feet once in wheelchair. R10 received OT with a start date of 3/3/24 and PT with a start date of 3/5/24.</p> <p>R10's admission physician orders dated 3/1/24, cardiac discharge instructions indicated that R10 should have as much activity as possible, but pulse should remain below 110 for 1 month following his procedure on 2/28/24. Please ambulate R10 to meals with front wheeled walker (FWW)/gait belt, assist of two staff, while monitoring his pulse and oxygen levels, followed by a wheelchair. PT to evaluate and treat. OT to evaluate and treat.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R10's PT evaluation indicated R10 required physical therapy related to status post hospitalization due to cervical cord compression, cervical decompression surgery, angiogram procedure, and functional decline. The plan of treatment dated 3/5/24, indicated frequency of one to five per week for duration of four weeks, intensity was identified as daily with certification period of 3/5/24 to 4/3/24. PT goals were as follows:</p> <ul style="list-style-type: none"> <li>-Patient will safely perform functional transfers with contact guard assist in order to facilitate increased participation with functional daily activities (Target date 3/18/24) Previous level of performance was independent; baseline on 3/5/24 was minimal assist.</li> <li>-Patient will safely ambulate on level surfaces 200 feet using FWW with Min assist 100% of the time while maintaining good balance to allow patient to get to bathroom with decreased assistance (Target date 3/18/24) Previous level of performance was unlimited distance independently; baseline on 3/5/24 was 200 feet with moderate assist.</li> <li>-Patient will increase dynamic standing balance to fair- and using righting reactions 100% of the time to right self in order to reduce the risk for falls (Target 3/18/24). Previous level of function was normal; baseline on 3/5/24 was poor+ moderate assist and upper extremity support to stand and reach ipsilaterally without LOB; unable to weight shift.</li> <li>-Patient will safely perform functional transfers with independely in order to facilitate increased participation with functional daily activities (Target 4/3/24). Previous level of function was independent; Baseline was on 3/5/24 was minimal assist.</li> <li>-Patient will safely ambulate on level surfaces 200 feet using FWW with modified independence 100% of the time while maintaining good balance to allow patient to get to bathroom with decreased assistance (target date 4/3/2024).</li> </ul> <p>R10's progress notes identified between 3/5/24 and 3/28/24, R10 completed only three physical therapy session on 3/7/24, 3/11/24, and 3/28/24.</p> <ul style="list-style-type: none"> <li>-PT Encounter Note dated 3/7/24, indicated physical therapy assist (PTA) completed the session. The note included R10 ambulated 200 feet with contact guard assist, was fatigued after 15 feet, and became unsteady. Patient does ambulate with ataxic gait pattern at times. Patient performs bed mobility with modified independence supine to sit. The note did not identify time duration of the visit.</li> <li>-PT Encounter Note dated 3/11/24, indicated physical therapist (PT)-A completed the session. The noted included Patient implemented gait training to progress functional ambulation ability and independence. Patient required contact guard assist during ambulation for safety. R10 ambulated 2 x 400 feet with FWW. Will progress as able. The note did not identify time duration of the visit.</li> <li>-PT Encounter note dated 3/28/24, indicated PT-B completed the session. The note included PT provided stand by assist during ambulation for safety. Gait training; gait training to normalize gait pattern, directional changes, training strategies to safely maneuver around obstacles and self correction during task performance. Patient ambulated 4 x 200 feet with 4WW. Continued skill PT services necessary to progress to modified independence with 4WW. The note did not identify time duration of the visit.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>All physical therapy notes and evaluations were requested. The requested documentation received from 3/5/23 through 3/28/24 did not include an evaluation of goal status and/or effectiveness of only having physical therapy once per week or the 3 (three) therapy sessions.</p> <p>During an interview on 3/27/24 at 5:15 p.m., director of nursing (DON) indicated that she started a walking program on or around 3/15/24, because facility did not have adequate therapy services in place and feared the residents would decline in their ability to walk and maintain strength. DON further indicated she was unsure if there was a decline in any residents functional ability to ambulate, however if they were not getting services consistently there was a risk they would decline or lose mobility.</p> <p>During an interview on 3/28/24 at 12:14 p.m., physical therapist (PT)-A, stated he was on a as needed basis (PRN) and attempted to get to the facility on ce a week. PT-A stated that he did not know who was providing the PT sessions when he was not in the building. There was only one intermittent therapy assistant and was not aware of what the PTA's schedule was. PT-A stated the lack of having a full time PTA was hurting the residents because although there may not be an overall decline the patients were not progressing like when the therapy department had more help. Further though there had been some residents that had been discharged from therapy that he feels should not have been. PT-A could not think of specific examples. PT-A indicated the facility had been doing teletherapy and did not like doing things that way, he preferred to see the patients in person. PT-A indicated he did not think the facility had been admitting resident who required skilled care because there was not an adequate number of staff to provide the necessary services.</p> <p>During an interview on 3/28/24 at 4:35 p.m., director of therapies (DOR)-A, stated that he was a Certified Occupational Therapy Assistant (COTA). DOR-A stated he was at the facility 3-5 times per week to provide occupational therapy services. DOR-A explained the facility switched therapy companies on 2/1/24. The PT-A only comes in about once a week with no set day. DOR-A would inform PT-A when new residents were admitted to the facility. DOR-A confirmed that the facility did not employee a full time PTA and PTA had not been at the facility for about 3 weeks. DOR-A further indicated that the facility was actively working on hiring physical therapist and physical therapy aides to meet the residents' needs.</p> <p>Request for policies for therapy was requested but not received.</p> <p>Facility Assessment last reviewed by the quality assurance committee identified the facility provided PT/OT services. Part 3: Facility Resources needed to provide competent support and care for our resident population every day and during emergencies included: Therapy Services (e.g., OT, OTA, PT, PTA .)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42355</p> <p>Based on observation, interview and document review, the facility failed to implement infection control practices in accordance with Centers for Disease Control (CDC) recommendations to prevent and/or mitigate the risk of the spread of communicable disease Influenza such as utilization of appropriate personal protective equipment (PPE), appropriate hand hygiene, preventing ill staff from working, implement active symptom screening for residents and staff, and providing staff ongoing education during outbreak. The facility's failures resulted in an Influenza A outbreak that effected 9 out out of 23 residents and had the potential to effect the remaining residents, visitors, and staff.</p> <p>Findings include:</p> <p>During entrance conference on 3/27/24, State Agency was made aware of an Influenza A outbreak in the facility. The outbreak started that began on 3/16/24, effected 9 out of 23 residents. Five residents were on isolation precautions at the start of the survey. and is continuing and affecting nine out of 23 residents. Five residents (R7, R11, R13, R14 and R15).</p> <p>Review of the facility's resident influenza A and isolation line listing, identified the following:</p> <p>R3 tested positive on 3/16/24, and ended isolation on 3/23/24,</p> <p>R6 tested positive on 3/17/24, and ended isolation on 3/24/24,</p> <p>R16 tested positive on 3/18/24, and ended isolation on 3/25/24,</p> <p>R9 started isolation on 3/18/24, and ended isolation on 3/25/24,</p> <p>R12 started isolation on 3/19/24, symptomatic but tested negative,</p> <p>R4 started isolation on 3/19/24, symptomatic but tested negative,</p> <p>R15 tested positive 3/20/24, and ended isolation on 3/27/24,</p> <p>R14 tested positive on 3/21/24, and ended isolation on 3/28/24,</p> <p>R11 tested positive on 3/21/24, and ended isolation on 3/28/24,</p> <p>R7 tested positive on 3/22/24, and ended isolation on 3/29/24,</p> <p>R13 tested positive on 3/22/24 and ended isolation on 3/29/24.</p> <p>In review of the facility's IC surviellance program activities, it was not evident employee illness line listing was completed, no record of employee or resident active screening, and not evident audits and education were completed after Influenza outbreak.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/28/24 at 10:19 a.m., assistant director of nursing (ADON) who identified herself as the infection preventionist (IP) and responsible for the facility's infection control (IC) surveillance program. IP reviewed active surveillance line listing and IC program activities. IP stated line listing for residents identified nine residents; R3 who resided on the east hallway was the first positive case on 3/16/24. Then on 3/17/24, the virus spread to the west hallway and four more residents R6 and R16 tested positive/R4 and R12 were symptomatic but tested negative. On 3/20/24, three more residents (R15, R14, R11) tested positive. R7 who resided on the west hallway tested positive on 3/22/24 and R13 who resided on the east hallway tested positive on 3/22/24. IP indicated consistent staffing was attempted however was not followed by NAs. IP reported active symptom screening for residents was never implemented because she had not been aware of the CDC guidance and recommendation. IP reviewed the illness tracking for staff, she confirmed tracking for staff was not completed and had not been completed in real time. IP explained staff would not communicate illnesses with her and the department managers would not communicate ill calls. IP would update the form when she became aware, sometimes days later. IP stated the facility had not implemented active screening for staff, she was unaware of that recommendation by the CDC as a prevention strategy. IP referenced the staff line listing on 3/18/24, which identified the dietary manager (DM)-A came in sick to work. IP had told her to go home because she did not look well however, DM-A did not go home, continued to work in the kitchen with residents food, refused to get tested, and shortly there after multiple dietary staff became ill with the flu. IP explained audits that would identify causal factors of spread and to identify staff education to prevent or mitigate the risk of further spread of the virus were not completed because she was not afforded enough time. IP stated she had continuously spent a lot of time out on the floor providing in the moment education to direct care staff because she had identified staff were not washing their hands nor using PPE appropriately. IP voiced frustration because despite ongoing constant reminders and education staff continued to not practice appropriate use of PPE or hand hygiene. IP explained she thought the influenza spread was related to several factors including staff not performing appropriate hand hygiene, wearing appropriate PPE and staff coming in sick to work. Furthermore, IP did not know that she had to report this influenza outbreak to the state agency (SA).</p> <p>Review of the facility's employee line listing for March 2024, identified the following:</p> <ul style="list-style-type: none"> <li>-DM-A had symptoms of sore throat, nasal congestions, diarrhea, and cough: Symptom start date 3/2/24, illness reported on 3/3/24, DM-A's lat shift worked prior to symptom onset was 3/1/24. DM-A returned to work on 3/5/24.</li> <li>-Nursing assistant (NA)-C had symptoms of fever that started on 3/17/24. NA-C reported symptoms on 3/18/24, NA-C's last shift worked prior to symptoms was 3/16/24, and returned to work on 3/21/24,</li> <li>-Licensed practical nurse (LPN)-A symptoms of cough and nasal congestion started on 3/17/24. LPN-A reported symptoms on 3/17/24 and worked on 3/17/24. LPN-A returned to work on 3/20/24. LPN-A was treated with Tamiflu (antiviral used to treat influenza),</li> <li>-DM-A had resumption of symptoms with headache and nasal congestion that started on 3/18/24. DM-A reported symptoms on 3/18/24 and worked. DM-A's last worked shift prior to symptom onset was 3/16/24. DM-A returned to work on 3/20/24,</li> <li>-NA-C symptoms of headache and fever, started on 3/18/24, reported on 3/18/24, last shift worked 3/16/24, and returned to work on 3/22/24,</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-DA-D symptoms of cough, headache, sore throat, and nasal congestion, started on 3/20/24, reported on 3/20/24, last shift worked 3/19/24, and returned to work on 3/22/24,</p> <p>-NA-E symptoms of chills and headache, started on 3/20/24, reported on 3/20/24, last shift worked 3/19/24, and returned to work on no date listed,</p> <p>-C-B symptoms of cough, fever, headache, nasal congestion, started on 3/21/24, reported 3/21/24, last shift worked 3/21/24, and returned to work on 3/27/24</p> <p>-ADON symptoms of chills, cough, fever, body aches, started on 3/22/24. Reported on 3/22/24, last shift worked 3/21/24 and returned to work on 3/27/24,</p> <p>-AA symptoms of runny nose and nasal congestions, started on 3/26/24, reported 3/26/24, last shift worked 3/26/24 and returned to work on 3/27/24, symptoms lasted less than 24 hours.</p> <p>All above employees tested negative for COVID 19.</p> <p>During an observation on 3/27/24 at 1:21 p.m., trained medical aide (TMA)-B was observed in R13's room who was droplet contact precautions without PPE on. There was a sign posted on the door that directed the use of gloves, gown for contact precautions and gown, gloves and face mask for droplet precautions. TMA-B was not wearing any PPE when observed walking away from R13 to exit the room. TMA-B confirmed R13 had influenza A and TMA-B should have been wearing a mask at least.</p> <p>During a tour of facility on 3/27/24 at 4:30 p.m. observed five residents (R7, R11, R13, R14 and R15) had Contact and Droplet isolation signs on the doors of their room; all of the room doors were open. At 4:35 p.m., nursing assistant (NA)-J and NA-F were observed going in and out of resident's room, including those on isolation, providing cares to different resident's without changing their facial masks, R2-(on isolation or already had?), R11, R14 and R16 (on isolation or already had?).</p> <p>Observation of the DM on 3/27/24 and 3/28/24 at various times was of her coughing and sneezing while working both in and out of the dietary department. She was observed wearing a mask, which was covering her mouth, but not her nose. When questioned regarding persons working when ill, DM reported she had stayed home when she was ill the previous week but did not have a fever and needed to cover shifts. DM reported she had been asked to be tested for Influenza-A but declined and reported that was what residents and other staff had, so she didn't feel she needed to spend the money to be tested .</p> <p>During an observation on 3/28/24, at 10:15 a.m. all five residents who were on contact precautions had their doors open.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 3/28/24 at 10:17 a.m., R14's room had a sign on the door that directed the use of droplet precautions. R14 laid in bed resting peacefully without evidence of agitation or restlessness. NA-A was observed going into R14's without any PPE on. NA-A walked over to R14 leaned down to talk into R14's ear, inches away from his face and touched R14's bed. NA-A then walked out of R14's room without performing hand hygiene. When questioned about hand hygiene and PPE usage, NA-A raised her hands in the air and confirmed R14 required droplet precautions and staed, No I did not put on a gown or mask. NA-A quickly turned and walked down the hallway into another resident's room who was on hospice, had not had Influenza A, and did not have symptoms of illness. NA-A had not performed hand hygiene prior to entering this residents room. When NA-A walked out of the room she again did not perform hand hygiene.</p> <p>Review of facility policy Influenza, Prevention and Control of Seasonal, indicated:</p> <p>-section symptomatic residents and visitors, 6b: providing instructions before visitors enter residents' room, on hand hygiene, limiting surfaces touched and use of PPE while in resident's room.</p> <p>-Under section symptomatic healthcare workers, 2. Staff who develop fever and respiratory symptoms are: a. instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor and the IP and/or designee before leaving work; b. excluded from work until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines). Those with ongoing symptoms will be considered for evaluation by the IP and/or designee to determine appropriateness of contact with residents.</p> <p>-under infection precautions, 1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven days after the illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.</p> <p>Review of facility policy Influenza, Prevention and Control of Seasonal, indicated:</p> <p>-section symptomatic residents and visitors, 6b: providing instructions before visitors enter residents' room, on hand hygiene, limiting surfaces touched and use of PPE while in resident's room.</p> <p>-Under section symptomatic healthcare workers, 2. Staff who develop fever and respiratory symptoms are: a. instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor and the IP and/or designee before leaving work; b. excluded from work until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines). Those with ongoing symptoms will be considered for evaluation by the IP and/or designee to determine appropriateness of contact with residents.</p> <p>-under infection precautions, 1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven days after the illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>42355</p> <p>Based on interview and document review, the facility failed to ensure the facility determined the required time needed for the infection preventionist based on the facility assessment, resident census and characteristics, and during communicable disease outbreaks. Further failed to ensure the IP was afforded adequate time and resources to effectively execute infection control program activities to prevent and/or mitigate the risk of infectious spread.</p> <p>Findings include:</p> <p>SEE F812: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique during 1 of 1 meal service. This had the potential to affect all 23 residents in the facility.</p> <p>SEE F880: Based on observation, interview and document review, the facility failed to implement infection control practices in accordance with Centers for Disease Control (CDC) recommendations to prevent and/or mitigate the risk of the spread of communicable disease Influenza such as utilization of appropriate personal protective equipment (PPE), appropriate hand hygiene, preventing ill staff from working, implement active symptom screening for residents and staff, and providing staff ongoing education during outbreak. The facility's failures resulted in an Influenza A outbreak that effected 9 out out of 23 residents and had the potential to effect the remaining residents, visitors, and staff</p> <p>During entrance conference on 3/27/24, state agency (SA) was made aware of facility outbreak of Influenza A, with nine out 23 residents diagnosed with Influenza A. Five residents remained on isolation.</p> <p>During an interview on 3/28/24 at 10:19 a.m., IP stated that she did not have a set number of hours to spend on infection control, was not aware of how many hours she was supposed to dedicate for infection control activities, and had not logged any hours. IP guessed since her employment started in November of 23, she has probably only worked a total of 40 hours on infection control activities. IP stated she also was the assistant director of nursing (ADON). In the ADON role she assisted with meeting residents needs, answering call light, she managed all the wound, responsible for staff education and orientation of new employees. IP stated she strongly felt enough time had not been dedicated to infection control; IP explained she had not implemented active symptom screening for residents and staff after the Influenza outbreak. IP did not complete any infection control audits or document staff education she had provided in the moment because there was not enough time. IP was not aware of how she was supposed to complete other job tasks that she was responsible for and dedicate necessary hours to infection control that would have been beneficial in preventing further positive cases of influenza.</p> <p>(continued on next page)</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the infection prevention program policies titled Surveillance for Infections stated the IP will conduct ongoing surveillance for healthcare-associated infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The policy did not identify required time needed for the IP to perform and implement the facilities infection surveillance program based on a comprehensive assessment of the resident population and/or during times of communicable disease outbreaks.</p> <p>Review of the Facility Assessment last reviewed by the quality assurance committee on 7/28/23, did not identify required time needed for the infection preventionist based on the resident population.</p> <p>IP job description for IP was asked for but not received.</p>