STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY VIEW MANOR HCC	200 EAST NINTH AVENUE LAMBERTON, MN 56152

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, during an Infection Control Focus survey for COVID-19, the facilty failed to ensure staff were actively screened for symptoms of COVID-19 prior to entering the facilty, ensure appropriate personal protection equipment (PPE) (eye protection) was worn by staff who provided direct care, and implement daily infection control surveillance according to Centers for Medicare and Medicaid Services (CMS), Centers for Disease Control (CDC) guidelines, and laundered fabric source control masks appropriately. This had the potential to affect all 38 residents in the facilty. Findings include: SCREENING Observation on 4/30/20 at 8:27 a.m., of the COVID-19 screening process during entrance to the facility identified a sign was posted at the front entrances of the facilty restricting visitors, and instructed visitors to enter the facilty at the Northeast entrance. Surveyors were escorted into the facility to the nurse's station at the entrance of the facilty to be screened. Interview on 4/30/20 at 8:33 a.m., with dietary aid (D)-A identified staff were required to enter the facility through the front entrance. Staff performed hand hygiene and donned their masks then entered the building to be screened for symptoms of COVID-19 at the nurse station. Interview on 4/30/20 at 8:38 a.m., with nursing assistant (NA)-C identified all facility doors were locked. The designated entrance was at the Northeast entrance. Staff were required to ring the door bell. An on-duty staff answered the door remotely to answer questions for symptoms of COVID-19. Staff performed hand hygiene, donned a mask, and entered the building and were screened for symptoms of COVID-19 at the nurse desk. If a person had a fever or respiratory symptoms when asked COVID symptom questions remotely, they were sent home and the director of nursing (DON) was contacted. No active screening including the taking of temperatures to check for presence of fever took place prior to entry. Interview on 4/30/20 at 8:39 a.m., licensed practical nurse (LPN)-B identified all staff entered through the designated entrance in the front of the building to be screened at the nurse's station after performing hand hygiene and donned a face mask. Staff were screened after they entered the facilty at the nurses station. Interview on 4/30/20 at 8:47 a.m., with the housekeeping director identified staff were actively screened for symptoms of COVID-19 after they had already entered the facility at the nurse's station. All doors were locked to prevent persons from entering. All staff had to ring the doorbell to enter. They were screened before the start of their shifts by asking if they had any symptoms of COVID-19, but temperatures and visual assessment would not occur until staff proceeded to the nurses station. No active screening took place prior to entry. EYEWEAR Observation on 4/30/20 at 8:27 a.m., of PPE use upon entrance identified several unidentified direct care staff wore no face shields or eye protection. Interview on 4/30/20 at 10:50 a.m., with NA-D identified staff wore face shields on 4/27/20 after being instructed to wear them by management. On 4/28/20, staff were instructed not to wear the face shields if in direct care, and use only when symptoms of COVID-19 were present in the facilty. Interview on 4/30/20 at 10:55 a.m. with NA-C identified face shields were distributed to staff on 4/27/20 to wear. The face shields were not easy to use and caused her to have headaches. The administrator contacted the corporate office, and on 4/28/20, the corporate office clarified face shields were to be worn only if COVID-19 symptoms were present in the facilty, or confirmed when the facilty had confirmed COVID-19 cases. Interview on 4/30/20 at 1:28 p.m., with LPN-B identified the facilty distributed face shields for staff to wear on Monday for staff to wear if symptoms of COVID-19 became present in the facilty. Interview on 4/30/20 at 3:20 p.m., with the DON identified the facilty was supplied with face shields from the corporate office. Every staff received a face shield on 4/27/20, and were instructed to wear them during their shift. The corporate office received complaints from staff the face shields were difficult to work with and some staff had difficulty breathing when wearing them. On 4/28/20, the administrator received directives to wear face shields only when COVID-19 symptoms were present, or when confirmed COVID cases were identified in the facility. The DON felt face shield supplies were limited, and corporate wanted to save equipment for active cases, even though they may be disinfected between use. Goggles were ordered for staff to wear in lieu of face shields, however the facility chose not to utilize current available PPE eyewear. SURVEILLANCE Review of 2020, February and March Monthly Infection Control Data Collection logs revealed that the facility had only tracked resident infections that were treated with an antibiotic. The form identified the resident name, infection site, type, date infection identified, culture date, and organism. It also included the date and type of antibiotic prescribed, and the antibiotic discontinued date. The form also identified which clinical data and precautions were used. The facility did not identify infections that were [MEDICAL CONDITION] in nature or for which an antibiotic was not ordered. The Monthly Infection Control Data Collection for Employee Illness identified employee name, department, infection symptoms, site, and type of infection, the infection onset date, start date of antibiotic use, doctor recommendations, and precautions taken. However, the employee form was not filled out with the information identified on form it did contain symptom/reason for the employee call-in. Interview on 4/30/20 at 1:31 p.m., with the infection preventionist (IP) identified prior to 2/27/20, the facility was not currently tracking [MEDICAL CONDITION] infections. IP provided documentation for training for nurses on 2/27/20 which identified the need for early detection and prevention of infections. The training information identified using the line listing that was attached, attached was Influenza-like Illness (ILI) Line List for Long-Term Care Facilities. Documented on that form was one residents information dated 4/16/20. IP identified this had been the only time that the form had been used so far that she could find. IP identified she correlated information between the staff and residents at the end of each month. IP identified she would document trending on the report she completed for the infection control committee, but felt there was usually no trending, so that had not currently occurred. Review of the 4/1/20, Infection Control Committee Agenda meeting minutes identified infections with a list of resident names next to the infection as : Pneumonia- one resident, urinary tract infection [MEDICAL CONDITION] -four resident(s), [MEDICAL CONDITION]/soft tissue/wound- three resident(s), eye -one resident, other -one resident. Listed below the identified infections was the word Trending with no documentation. On the last page of the report was another area that had the word trending identified which read no trending between res/staff, staff to staff. The last page further identified a COVID-19 binder had been developed, audits of hand hygiene and personal protective equipment (PPE) donning and doffing had been completed. The facility had been in lock down since 3/13/20. The only visitors allowed were those of the resident at end of life care. There was lack of evidence that the facility reviewed or investigated the developed infections for potential causes. The report lacked analysis of identified infection for trends, identified comparisons, tracking for clusters within the facility, education or implementation of interventions to reduce or prevent infection. Interview on 4/30/20 at 3:15 p.m., with IP who verified she had not been analyzing the infection control data that had been collected. IP identified she did not document information but was [MEDICAL CONDITION] for it such as if someone has recurrent UTI's and where things are in the facility. Interveiw on 4/30/20 at 3:20 p.m., with director of nursing (DON) identified her expectation was the infection control surveillance had been completed per the facility policy. DON expectation is for real time surveillance and looking for trends and identifying early. DON identified the IP had completed surveillance at least monthly but had been unaware it had not been documented. Interview on 4/30/20 at 3:49 p.m., with

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) facility nurse consultant identified her expectation would be staff utilized the dashboard on point click care for antibiotic use and to accurately document using line item for signs and symptoms of infections without antibiotics. The nurse consultant identified she reviewed data from the dashboard for the facility also and contacted them with any irregularities she identified during her audit. She further expected the IP to track and trend the surveillance data that had been collected. Review of the 3/2010, facility's Infection Control Surveillance program policy identified staff were to promptly identify individual infections and trends within the facility to prevent the spread and provide treatment to residents and staff. The facility staff were to keep records of suspected infections for review by the Infection Control Committee. The staff were to document signs/symptoms of infection when exhibited by resident. The Infection Preventionist (IP) would provide education and/or consultation as needed. The IP was to complete a report quarterly and present at the Quality Improvement (QA) meeting and have report available for the staff to review. Review of 3/2010, Outbreak Investigation Infection Control policy identified staff were to list illnesses of residents, complete education, identify the nature of an outbreak and review control and prevention measures.