DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 8, 2020

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

RE: CCN: 245378
Survey Start Date: April 30, 2020

Suspension of Survey/EnforcementActivities

Dear Administrator:

On May 15, 2020, we notified you a remedy was imposed. On June 5, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 23, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies have been suspended and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
May 15, 2020

Administrator
Valley View Manor HCC
200 East Ninth Avenue
Lamberton, MN 56152

SUBJECT: SURVEY RESULTS
CCN: 245378
Cycle Start Date: April 30, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 30, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Valley View Manor Hcc to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the April 30, 2020 survey. Valley View Manor Hcc may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. An acceptable ePOC will serve as

your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, Unit Supervisor
Minnesota Department of Health
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 30, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Minnesota Department of Health
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Valley View Manor Hcc may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. BUILDING _____ B. WING _____	04/30/2020

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

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 4/30/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 4/30/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/23/20

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

Electronically Signed | 05/21/2020

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 880	Continued From page 1 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 2 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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	F 880	The facility remains Covid-19 free. No individual residents were affected in this area. All residents that have the potential to be affected in this area due to an institutionalized setting and multiple risk factors makes all residents in long term care facilities at high risk for infection. By educating our staff on the COVID-19 GUIDELINES AND PROCEDURES FOR ALL FACILITIES (including assessment screening at the door prior to entrance,	

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F 880	Continued From page 3 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.	F 880	proper use of PPE/eye protection, and cleaning of fabric masks, and active current infection surveillance) will ensure compliance in this area. Current residents continue to be assessed for covid-19 virus symptoms at least daily. All staff were educated on the “COVID-19 GUIDELINES AND PROCEDURES FOR ALL FACILITIES” with a focus on the need for all staff to be assessed for covid-19 prior to the entrance to the facility, Extended use of PPE/eye protection and disinfecting, and changing of resident fabric masks daily. Education will be provided in small groups, at shift changes, department meetings, and 1:1 education. An audit was created and will be completed by the infection preventionist, or designee, to monitor system and documentation compliance of all staff entering the building. The audit reviews the following areas: all staff are wearing a face shield or safety glasses every shift, cleaning and storage of extended use of safety glasses or face mask, daily exchange of fabric masks for residents, and Infection Control Surveillance through an active current line list of infection surveillance and summary report that include investigation into type of organism and infection sources/cultures, patterns of trends or cluster, education to staff and new intervention tried to reduce the number of infections in the center. The audit will be completed 3x weekly X 2 weeks, then 2 X per week x 2 weeks, then weekly x 4 weeks. The audit results will	

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F 880	Continued From page 4 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	F 880	be reported to the QAPI Committee for further review and recommendations. The QAPI Committee will determine when the audits may be discontinued.	

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F 880	Continued From page 5	F 880		

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

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F 880	Continued From page 6	F 880		

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 viral 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 viral-like 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

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F 880	Continued From page 7 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 (UTI) -four resident(s), Cellulitis/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 watchful 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	F 880		

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F 880	Continued From page 8	F 880		

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 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.