Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 1, 2024

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

RE: CCN: 245566
Cycle Start Date: March 13, 2024

Dear Administrator:

On April 25, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 1, 2024

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

Re: Reinspection Results
Event ID: PU4812

Dear Administrator:

On April 25, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 13, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered
April 1, 2024

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

RE: CCN: 245566
Cycle Start Date: March 13, 2024

Dear Administrator:

On March 13, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. 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.

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.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 13, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 13, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

(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 On 3/11/24 through 3/13/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a 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 facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/11/24 through 3/13/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55661430C (MN98720). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		4/11/24

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

Electronically Signed — 04/05/2024

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 684	Continued From page 1 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to appropriately assess a change of condition (COC) for 1 of 2 residents (R9) reviewed for hospitalization who had changes from his baseline health status when oxygen (O2) levels were assessed to be low. The facility failure in assessment resulted in R9 being transported to the emergency department. Findings include: R9's 12/19/23, quarterly Minimum Data Set (MDS) assessment identified R9 had diagnosis of chronic obstructive pulmonary disease (COPD), epilepsy (seizure disorder), malnutrition, schizophrenia, anxiety, depression, quadriplegia (paralysis of the limbs), atrial fibrillation (abnormal heart rhythm) , and dysphagia (swallowing disorder). R9's cognition was intact, he was able to communicate, and he was totally dependent on staff for activities of daily living. R9's current administration record identified he has a physician order started on 10/24/23, for as needed oxygen at 1 LPM (liter per minute) via NC (nasal cannula) due to decreased O2 saturations to maintain oxygen saturations greater than 90%.	F 684	R9 was readmitted to the hospital on 3/28/24 due to change of condition. Change in a Resident□s Condition or Status Policy and Procedure was reviewed on 4/3/2024. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) All licensed staff will be educated on the facility policy change of condition prior to our compliance date. Education included: change of resident condition, resident focused assessment, provider notification, and complete documentation. Education on the policy was initiated on 4/3/24. On-call staff who have not been scheduled to work prior to our compliance date will be educated prior to their next scheduled shift. All licensed nurses have been assigned and will complete prior to our compliance date an education course related to assessments.	

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F 684	Continued From page 2 Check oxygen saturations every shift and as needed. Monitor every shift for signs and symptoms of respiratory distress as evidenced by shortness of breath. Notify physician if oxygen remain less than 90% (percent). During an observation and interview on 3/12/24 at 1:14 p.m., R9 was laying down and noticed a slight tremor. R9 was awake and alert during our interaction and was able to answer yes or no questions about his family and the photos on his wall but he was not able to recall any details regarding his illness or going to the hospital on 2/10/24. During an observation on 3/13/24 at 9:37 a.m., R9 was sitting up in his wheelchair watching television. R9 was smiling and alert, he would look towards the door when staff would walk by. R9's vital sign record was reviewed from 11/18/23 through 2/8/24. R9 received supplemental oxygen on 12/26//23 with an oxygen saturation of 90%. R9's oxygen saturations were checked every shift and generally ran from 90%-97%. R9's nursing progress notes identified on: -2/10/24, 6:32 a.m. a late entry from, registered nurse (RN)-B Resident was pallor (pale) and slow to respond to staff when he was addressed at 4:45 a.m. Resident was a-febrile (no fever)with his temperature at 98.6 tympanic, pulse 112, respirations 14, breathing shallow. Sa02 79%-83%. Resident was placed on 2L(liters) oxygen via concentrator at 5:00 a.m. Oxygen saturation was 90% on 2 liters at 5:20 a.m., with his pulse rate at 83. Continue to monitor status.	F 684	2) Director of nursing will complete 24-hour report audit 3 times weekly for 3 months to ensure any resident with change of condition is assessed and change of condition policy is followed. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training.	

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F 684	Continued From page 3 -2/10/24, 7:21 a.m., RN-C CNA called this nurse into room this morning. R9 appeared to be flushed in the face and warm. Temp was 101.3, he was on 1 liter of oxygen and his saturation was 82% I did turn him up to 3 liters and his oxygen's sats came up to 87%. his pulse is 113, respirations 32 per minute, blood pressure at 147/92. He has not yet had his morning medications. called on call provider and received verbal order to send to emergency department for evaluation. Lung sounds diminished in left side anterior fields right anterior fields are wheezy. -2/10/24 7:59 a.m., RN-C R-9 transported via ambulance to emergency department at 7:50 a.m., daughter and director of nursing notified. -2/16/24 Hospital discharge summary identified R9's sister reported to the attending physician that R9 had developed a cough a couple days prior, she identified that R9 is normally responses answers questions in short phrases but is typically pretty alert and not lethargic as described today. The summary identified R9 presented in the emergency department febrile at 103.8 and substantially tachycardia (elevated heart rate) with heart rates around 130. R9 was placed on 4 liters of oxygen per nasal cannula bringing his sats up to the mid 90's. Tylenol was given and temperature came down to 100. He was treated with IV antibiotics. Initially requiring 3-4 liters oxygen supplementation, however this increased to 5-6 liters. on 2/12/24 he was transferred to the intensive care unit (ICU) due to hypotension requiring pressors (medication used for severely low blood pressure) and he was started on a BIPAP (non-invasive ventilation for breathing) for further respiratory support. R9 was transferred back to the nursing floor on 2/14/24, when R9's	F 684		

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F 684	Continued From page 4	F 684		

blood pressure improved. R9's respiratory status continued to improve and return to baseline. R9 was deemed medically stable for discharge and returned to the facility on 2/16/24.

During an interview on 3/12/24 at 12:35 p.m., nursing assistant (NA)-B identified she went into R9's room on last rounds between 3:30 a.m. and 4:00 a.m., and found R9 to be "red faced and shaking really bad" NA-A identified R9 was not responding as he normally did and he was "staring at me incoherent and shaking" NA-A grabbed the thermometer and pulse oximeter but was unable to get a reading, she went and told the nurse. NA-A identified it was difficult to get a reading on the pulse oximeter but eventually it read 79%. It fluttered between 79%-83%. The nurse started R9 on oxygen and left the room. NA-A stated, "I don't feel like the nurse took my concerns seriously".

During an interview on 3/12/24 at 12:16 p.m., RN-B identified NA-B told her R9s hands were shaking a little, she checked his temperature, and it was 98.6, he was difficult to arouse. RN-B checked R9's oxygen saturation because "in the past when he was failing his oxygen would go down". She identified it had been about 3 months since they had to give him oxygen at night. RN-B reported on that night his oxygen saturations were between 79%-83% on room air but after she started him on 2L oxygen, his saturations came up to 90%. RN-B identified she did not complete a lung assessment and that was the end of her interaction with R9, she further revealed she did not return to R9's room to monitor his condition.

During an interview on 3/12/24 at 1:00 p.m., RN-C identified RN-B reported off to her at 6:00

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F 684	Continued From page 5 a.m., she told RN-B she told RN-C that R9's oxygen was low and that she started him on 2 liters oxygen. RN-C indicated went into R-9's room sometime later and found R9 warm to touch, shivering. RN-C identified she completed an assessment, Temperature, oxygen saturations were 82-84, temperature was high, and lung sounds were diminished. She increased R9's oxygen supplementation to 3 Liters and called for ambulance transfer to the emergency department. During an interview on 3/12/24 at 2:34 p.m., medical director identified she would expect nursing to follow the facility policy and notify the physician if a resident is experiencing a change in condition. She further identified she would expect registered nurses to have the ability to recognize the symptoms of severe infection and/or sepsis and she would have expected RN-B to have completed a comprehensive assessment to include lung sounds. The medical director also indicated it is important not to delay care when dealing with sepsis or any other serious change in condition as it could cause serious health consequences to the resident. During an interview on 3/12/24, at 1:45 p.m., RN nurse consultant stated, "as soon as they found R9 with an oxygen saturation of 79%-83% they should have called the on call doctor". During an interview on 3/12/24 at 1:36 p.m., director of nursing (DON) indicated she would have expected RN-B to immediately complete a comprehensive assessment to include lung sounds and update the physician per the facility policy. DON reports she has not done any competencies or face to face training on	F 684		

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F 684	Continued From page 6 assessments or change of condition before or after this incident. Review of the February 2021, Change of Condition Policy identified nursing were to notify attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing a standard disease related clinical intervention (is not self-limiting).	F 684		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 883		4/11/24

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F 883	Continued From page 7 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to appropriately vaccinate against pneumonia upon admission for 5 of 5 residents (R4, R7, R10, R16, and R20) who were reviewed for immunizations. Findings include:	F 883	R4, R7, R10, R16, and R20 received the PCV20 vaccine on 3/20/2024. Policy and procedure, Pneumococcal Vaccine, was reviewed on 4/3/24. All current residents in the facility were	

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F 883	Continued From page 8 A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal Vaccine-20 (PCV20) for patients who had received Pneumococcal Vaccine-13 (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R4's 2/01/24, significant change Minimum Data Set (MDS) assessment identified R4 was 89 years old. R4's MDS under Section O- Special Treatments and Programs indicated R4's pneumococcal vaccinations were up to date. R4's vaccination record identified she received PPSV23 on 12/11/03 followed by PCV13 on 3/20/15. However, the record lacked evidence R4 had received the PCV20 despite the consent for it being obtained last month. R7's 1/12/24, quarterly MDS identified R7 was 90 years old. R7's MDS under Section O- Special Treatments and Programs indicated R7's pneumococcal vaccinations were up to date. R7's vaccination record identified he received PPSV23 on 11/08/01 followed by the PCV13 on 11/28/18. However, the record lacked evidence R7 had received the PCV20 despite the consent for it being obtained last month. R10's 2/16/24, annual MDS identified R10 was 89 years old. R10's MDS under Section O- Special Treatments and Programs indicated R10's pneumococcal vaccinations were up to date.	F 883	audited to ensure they have received their Pneumococcal vaccine according to facility policy. Risk of re-occurrence will be minimized by the Director of Nursing or designee initiating the following: 1) Infection Preventionist will be educated on the facility policy Pneumococcal Vaccine prior to our compliance date. Education on the policy was completed on 4/4/24. Education included: facility process to ensure all new residents are assessed within 5 working days from date of admission for their pneumococcal vaccine status and obtain consent/decline, for any pneumococcal vaccines they may be eligible for. Education also included ensuring residents who consent to pneumococcal vaccines, receive the vaccine within 30 days of admission. 2) Audits will be completed 1 time weekly for 3 months on all new admissions to ensure they have received their Pneumococcal Vaccine per policy. Audits will be ongoing until reviewed at QA and a determination is made that they are no longer necessary. 3) Audits will be brought to the QA committee quarterly to discuss findings and need for further auditing and/or additional staff training.	

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	245566	A. BUILDING _____ B. WING _____	C 03/13/2024

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F 883	Continued From page 9 R10's vaccination record identified she received PPSV23 on 7/09/14 followed by the PCV13 on 8/07/17. However, the record lacked evidence R10 had received the PCV20 despite the consent for it being obtained last month. R16's 2/13/24, quarterly MDS identified R16 was 89 years old. R16's MDS under Section O-Special Treatments and Programs indicated R16's pneumococcal vaccinations were up to date. R10's vaccination record identified she received PCV13 on 5/31/2016 followed by PPSV23 on 10/24/17. However, the record lacked evidence R16 had received the PCV20 despite the consent for it being obtained last month. R20's 1/26/24, quarterly MDS identified R20 was 90 years old. R20's MDS under Section O-Special Treatments and Programs indicated R20's pneumococcal vaccinations were up to date. R20's vaccination record identified he received PCV13 on 3/20/15. However, the record lacked evidence R20 had received the PCV20 despite the consent for it being obtained a last month. Interview on 3/12/24 at 3:55 p.m., with registered nurse (RN)-A who is the facility infection preventionist (IP) stated immunizations were verified upon admission through MIIC (Minnesota Immunization Information Connection). IP stated the PCV were offered to residents and would collaborate with the local clinic for residents to receive the pneumococcal vaccine. Interview on 3/13/24 at 8:52 a.m., with nurse consultant (NC) stated the facility completed a vaccination audit when Center of Disease Control (CDC) announced pneumococcal mandates for	F 883		

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F 883	Continued From page 10 health care providers and acknowledged the facility had no process for compliance of the vaccine. NC agreed the facility had not administered the pneumococcal vaccines to residents. Interview on 3/13/24 at 9:47 a.m., with director of nursing (DON) stated her expectation would be for residents to receive the pneumococcal vaccines in a timely manner. Review of 2/19/24, Pneumococcal Vaccine policy identified the facility would conduct pneumococcal assessments within 5 working days of residents' admission to the facility and would provide pneumococcal vaccines, according to the Center of Disease Control (CDC), within thirty days of admission unless medically contraindicated, already immunized, or the resident declines the vaccine.	F 883		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/14/2024. At the time of this survey, VALLEY VIEW HEALTHCARE AND REHAB found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 04/09/2024

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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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. VALLEY VIEW HEALTHCARE & REHAB is a 1 story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1957, with additions following in 1976, 1988, and 2011. All to be determined as Type II (111). The original	K 000		

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K 000	Continued From page 2 building and all additions have no basement. Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. There is an assisted living facility which is separated from the nursing home by a 2-hour fire separation. The facility has a capacity of 35 beds and had a census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code,	K 291	K291 Emergency Lighting The Emergency Lighting log was reviewed and updated to reflect the individual	4/10/24

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K 291	Continued From page 3 sections 19.2.9.1, 7.9, 7.9.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed during documentation review that the documentation presented for review was generic in content, not providing confirmation of individual device testing, and the individual(s) that completed the monthly / annual testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	devices tested, the location of the device, date of testing, and the name of the individual that completed the testing. The Emergency Lighting testing log will be brought to the April 24, 2024, Quality Assurance meeting for review. The Emergency Lighting testing log will be brought to the QA committee monthly for three months to discuss findings and the need for any further auditing.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		4/10/24

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K 324	Continued From page 4 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper inspection and safety measures associate to residential cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed by observation that the residential stove-range located in the TCU Kitchenette and the Activities Area were not outfitted with lock-out, disconnect, 120 min max timeout hardware. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	K324 Cooking Facilities The TCU Kitchenette oven was disconnected from power by Hoskins Electric on 03/23/2024. A sign was put on the oven stating that the unit is non-operational. The Maintenance Supervisor verified by visual inspection, along with confirming by reviewing an invoice from Hoskins Electric, that the Activity room range/oven does have a 120 minute time out switch that was installed by Hoskins Electric on 07/12/2023.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		4/10/24

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K 353	Continued From page 5 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.3, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section(s) 8.5.5, 8.5.5.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed by observation that in the TCU - Linen Storage Closet the sprinkler head exhibited paint on the spray deflector 2. On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed by observation that sprinkler head(s) located in the Kitchen Dishwashing Area and the TCU Soiled Utility Room exhibited signs of loading and/or oxidation.	K 353	K353 Sprinkler System and Testing Summitt Fire Protection replaced the sprinkler heads in the Kitchen Dishwashing area and the TCU Soiled Utility Room on 04/02/2024. Summitt Fire Protection replaced the sprinkler heads in the TCU Linen Storage Closet on 04/08/2024. The Sprinkler Head Inspection Log has been revised for more frequent inspections of sprinkler heads in highly corrosive prone areas. The Sprinkler Head Inspection Log will be brought to the April 24, 2024, Quality Assurance meeting for review. The Sprinkler Head Inspection log will be brought to the QA committee monthly for three months to discuss findings and the need for any further auditing.	

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K 353	Continued From page 6 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.5. This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed by observation and a review of available documentation, records were not available to confirm and demonstrate that at least the last 12 monthly inspections have been performed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	K355 Portable Fire Extinguishers A monthly inspection of fire extinguishers was conducted on 04/04/2024. A new inspection log was created identifying the type of extinguisher, the location, the inspection date, any corrective action, and the signature of the person inspecting the fire extinguishers. The Fire Extinguisher Inspection Log will be brought to the April 24, 2024, Quality Assurance meeting for review. The Fire Extinguisher Inspection log will be brought to the QA committee monthly for three months to discuss findings and the need for any further auditing.	4/10/24
K 712 SS=D	Fire Drills CFR(s): NFPA 101	K 712		4/10/24

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K 712	Continued From page 7 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed by review of available documentation that documentation presented for review did not confirm that a fire drills was conducted for 1st shift - 1st Quarter. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 712	K712 Fire Drills Fire will drills be conducted at unexpected times and under varying conditions, at least quarterly each shift. A fire drill was conducted on the first shift on 03/26/24 at 10:00 a.m. The Maintenance Director will maintain fire drill logs to review for a minimum of 13 months. The Fire Drill Log will be brought to the April 24, 2024, Quality Assurance meeting for review. The Fire Drill log report will be brought to the QA committee monthly as part of the Safety Meeting report to review.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K 923		4/10/24

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K 923	Continued From page 8 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.2.3, 9.3.7,9.3.7.5.2, 9.3.7.5.3. This deficient	K 923	K923 Gas Equipment – Cylinder and Container Storage All cardboard and combustible materials were removed from the Med Gas Storage	

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(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
K 923	Continued From page 9 finding could have a widespread impact on the residents within the facility. Findings include: On 03/14/24 between 10:00 AM and 2:00 PM, it was revealed by observation that the Med Gas (O2) Room contained combustible storage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	room on 03/14/2024. Signage has been added to the exterior door, as well as inside the room stating, “no cardboard in this room”. Audits will be completed 1 time weekly for 3 months to ensure that there are no combustibles or cardboard stored in the Med Gas Storage room. Audits will be brought to the QA committee monthly for three months to discuss findings and the need for further auditing and/or additional staff training.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 1, 2024

Administrator
Valley View Healthcare & Rehab
510 East Cedar Street
Houston, MN 55943

Re: State Nursing Home Licensing Orders
Event ID: PU4811

Dear Administrator:

The above facility was surveyed on March 11, 2024 through March 13, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00286	A. BUILDING: _____ B. WING _____	C 03/13/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/11/24 through 3/13/24 a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55661430C (MN98720) and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state	2 000		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		4/11/24

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21426	Continued From page 3 Based on interview and document review, the facility failed to complete tuberculosis (TB) symptom screening and tuberculin skin testing (TST) for 1 of 1 resident (R20) reviewed for TB. Findings include: R20's medical record, identified an admission date of 7/20/2022. R20's vaccination records lacked a completed tuberculin symptom screening and two step TST administration. The Centers for Disease Control (CDC) guidelines for preventing the transmission of mycobacterium tuberculosis (TB) in Health Care Settings, 2019, directed that all residents and staff (Pre-placement) must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. Interview on 3/14/24 at 09:48 a.m., with the director of nursing (DON) stated her expectation would be for residents should be screened for tuberculosis, a two step Mantoux should be offered, and the results should be documented. Review of October 2018, Infection Prevention and Control Program identified the facility would implement measures to process surveillance, identify potential and current infections, and enhance screening guidelines in accordance with Centers for Disease Control (CDC). Review of August 2019, Tuberculosis Infection Control Program identified the Infection Preventionist (IP) would enforce infection control surveillance methods to screen residents and	21426	Corrected	

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21426	Continued From page 4 employees of latent and/or active nosocomial (also known as a healthcare-associated infection (HAI), is an infection that a person acquires while receiving medical treatment in a healthcare facility) transmission of TB. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions as well as current residents to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		