Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 10, 2024

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

RE: CCN: 245378
Cycle Start Date: March 29, 2024

Dear Administrator:

On May 3, 2024, the Minnesota Department of Health 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 10, 2024

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

Re: Reinspection Results
Event ID: NZN012

Dear Administrator:

On May 3, 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 29, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 16, 2024

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

RE: CCN: 245378
Cycle Start Date: March 29, 2024

Dear Administrator:

On March 29, 2024, a survey was completed at your facility by the Minnesota Department of Health 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 29, 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 29, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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April 16, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: NZN011

Dear Administrator:

The above facility was surveyed on March 27, 2024 through March 29, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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 ______	C 03/29/2024

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
F 000	INITIAL COMMENTS	F 000		

On 3/27, 3/28 and 3/29/24, a standard abbreviated survey was conducted at your facility. 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, H53782350C (MN101891, MN101946), H53782602C (MN102021, MN102025, MN101968), H53782563C (MN101971), H53782564C (MN100218), and H53782565C (MN101970),
with a deficiency issued at F567, F580, 801, F812, F825, F880, and F882.

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 that substantial compliance with the regulations has been attained.

F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii)	F 567		4/24/24

§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.
(i) The facility must not require residents to deposit their personal funds with the facility. If a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/23/2024

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 567	Continued From page 1 resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents had access to their personal funds upon request for 1 of 1 resident (R5) reviewed. This had the potential to effect 14 residents who utilized a personal funds account.	F 567	Resident R 5 met with the Business Office Manager (BOM) to review the current amount of their resident funds. A grievance form will be completed for R 5 with plan and resolution documented. All current residents and future residents who	

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F 567

Continued From page 2

Findings include:

During an interview on 3/28/2 at 10:19 a.m., R5 stated she was able to access her money only when administration or the business office was open. She could not access her personal funds on weekends or holidays.

During an interview on 3/28/24 at 2:00p.m., licensed practical nurse (LPN)-A indicated if a resident wants funds they have to go to the administrator or the business office manager during business hours.

During an interview and observation on 3/28/24 at 2:26 p.m., the administrator indicated residents do have access to their money after hours and thought there was $30.00 in the medication room in a cash box if a resident requested money. Further indicated all staff should know how to access it. The administrator requested the assistance of LPN-A to gain access to the medication room holding the cash box but had difficulty locating the cash box and the key to open the box. After 5-10 minutes, the keys were located and the cash box was opened to reveal $45.00 cash in the box with the last noted withdrawal of $5.00 on 3/3/2020. LPN-A stated she did not know the cash box was there.

During an interview on 3/28/24 at 4:00 p.m., the assistant director of nursing (ADON) stated the residents only had access to their funds when the administrator or the business office manager were in the facility. ADON indicated she was unaware of any money in the medication room for resident use or how to access it.

F 567

funds are managed by the facility will have their amounts reviewed and the resident/representative will be notified that resident requests for access to their funds should be honored by facility staff as soon as possible but no later than: the same day for amounts less than one hundred $100 ($50 for Medicaid residents) and three banking days for amounts of $100 ($50 for Medicaid residents) or more. Petty cash is also available at the facility.

The licensed nurses and BOM was in-serviced on the Deposit Resident Funds Policy with focus on item #1 c on having funds available upon resident request and at the specified time periods and the location of funds for weekend disbursement. The residents will also be notified of this policy and procedure and timeframes in which funds care available will be explained at the next resident council meeting.
The Administrator and/or designee is responsible for compliance.
Audits on resident funds request, timely disbursement and weekend fund requests will begin 2x week for 4 weeks then monthly to ensure sustained compliance.
Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation.
Compliance: 4/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 567	Continued From page 3 The facility's policy titled, Deposit of Resident Funds last updated 8/15/23, indicates resident requests for access to their funds should be honored by facility staff as soon as possible but no later than the same day for amounts less than one hundred $100 ($50 for Medicaid residents) and three banking days for amounts of $100 ($50 for Medicaid residents) or more.	F 567		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		4/24/24

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F 580	Continued From page 4 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide required timely notifications for 1 of 2 residents (R4) who experienced falls. Findings include: R4's 3/17/24 Significant change Minimum Data Set (MDS) assessment identified she was on hospice services (3/7/24), her cognition was intact, and she required supervision and assistance with her Activities of Daily Living (ADLs). R4 had diagnoses of dementia, malnutrition, history of falls and urinary incontinence. R4 experienced 3 documented falls in the month	F 580	R 4 has since discharged from the facility. All other residents who experienced a fall, their risk management incident will be reviewed for family/MD notifications and notifications will be made and/or risk management incident updated as needed. Future residents who experience a change in resident care, the resident/resident representative will be notified, and documentation initiated. Licensed nurses will be in-serviced on the change in condition policy with focus on items #4-6 that resident, resident representative, and the MD will be notified of a resident change in condition, medication, treatment or change in mental status and documentation indicating that	

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F 580	Continued From page 5 March and family members expressed their concern regarding supervision and factors contributing to her falls. 1.) 3/11/24 at 1:45 p.m. R4 was found lying on the floor in her room with her walker next to her. Blood was noted on the floor and she had a large lump and a laceration on the back of her head. Additional minor injuries included skin tears on her left hand, right forearm, and ankle. R4's record indicated the family was notified. 2.) 3/20/24 at 5:00 p.m. R4 was walking in the hall with her walker and had a gait belt around her waist. An unidentified staff person was walking behind R4 with no contact on resident's gait belt. The report identified the walker got ahead of her, she lost her balance and fell forward landing on her knees and obtained a moon shaped cut on her left knee. There was no documentation on either the report or resident record of notification of the director of nursing (DON). 3.) 3/21/24 at 5:55 p.m. R4 was discovered lying on the floor in front of her chair with a large hematoma (bruise) noted on the left side of her forehead above her left eye, below the hair line. Further assessment identified a small skin tear on her left elbow. There was no documentation on either the Incident report or resident record of notification of the responsible party or family members. Interview on 3/27/24 at 1:54 p.m., during R4's care conference with multiple family members and the hospice registered nurse (RN) identified R4 had been a resident at the facility since March of 2021. FM-A with agreement from other FM's in attendance reported they had not had concerns with R4's care and safety until the past month when she experienced 3 falls. Family member (FM)-A (designated for notification) reported she	F 580	notification was initiated. Director of Nursing and/or designee will be responsible for compliance. Audits on notification of change in resident condition documentation to resident representative and MD will begin weekly x 3 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendation. Compliance: 4/24/2024	

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F 580	Continued From page 6	F 580		

was not notified by the facility and was not aware of R4's fall on 3/21/24. FM-A reported her concern with not receiving notification, especially with the amount of facial injury and questioned if there were additional incidents she had not been notified about. She reported R4 would not remember what had happened and the family had depended on the facility to take care of their family member and notify them if there were any areas of concern.

Interview on 3/27/24 at 3:43 p.m., with the director of nursing (DON) reported her expectation for all licensed staff to follow the facility policy for assessment and appropriate notification of the DON, medical provider, and family as soon as possible following an incident. She reported if a fall with no injury occurred during the night and family requested to wait until morning to be notified, that was acceptable. In the instance of R4's fall on 3/21/24 at 5:45 p.m., the family should have been notified once the assessment was completed to determine if they wanted R4 sent to the Emergency department for further evaluation. She also reported staff should have notified her following R4's fall on 3/20/24 and would need to investigate further.

Review of the October 4, 2021 Falls-Clinical Protocol Steps in the Procedure identified to evaluate for possible injuries, monitor vital signs, position the resident comfortably if no injury, and document relevant details. Notify the resident's attending physician and family in an appropriate time frame. Documentation recorded in the medical record was to include details of the fall, assessment data, any interventions implemented, notification of physician and family and signature and title of the person recording the data.

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F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		4/24/24

§483.60(a) Staffing
The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)

This includes:
§483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.

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(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically

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F 801	Continued From page 9 qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure all staff working in the dietary department had training on use of equipment, safe temperatures to ensure food safety and sanitation processes. This had the potential to affect all 23 residents in the facility. Findings include: Entrance conference on 3/27/24 at 9:15 a.m. with the director of nursing (DON) and administrator identified the facility was having issues with staffing in the dietary department and multiple staff were assisting with meal preparation and clean up. Both the DON and administrator reported they had assisted in the dietary department. The administrator reported she had worked as a dietary aide and assisted with cleanup. The DON reported she had done dishes and assisted with the dining room. Review of the dietary schedule for March 2024 identified 1 trained medication aide (TMA)-A scheduled as PM (evening meal) cook. Review of the January, February and March 2024 dietary schedules identified TMA-A worked 3 shifts in January 2024, 8 shifts in February 2024, and 9 shifts in March 2024 as the evening cook. Observation on 3/27/24 at 5:00 p.m., identified TMA-A in the dietary kitchen as the designated cook for the PM shift. She had worked on the nursing unit for the day shift with resident contact and then worked the PM dietary cook shift. Review of TMA-A's education record identified no specialized orientation to the dietary department,	F 801	The dietary staff completed Infection Control in the Kitchen and Handling Food Safely Part 1 and 2. There were no ill effects experienced by the residents for this deficient practice. Future employees to the dietary department will have the dietary training courses assigned upon hire and ongoing in-services will be conducted annually and as needed. The Culinary Director will be in-serviced on the Dietary Policies titled, Staffing the Food and Nutrition Services Department and the Training and Orientation Procedure with emphasis on completing the training categories and how to staff department in an emergency to and to ensure procedures are being followed and audited appropriately. The Executive Director and/or designee is responsible for compliance. Audits on dietary staff education completion will begin weekly x 2 weeks then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendations. Compliance: 4/24/2024	

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F 801	Continued From page 10 nor was there documentation on the electronic RELIAS education of any courses related to dietary management or food safety. Interview on 3/27/24 at 4:34 p.m., with cook-C reported she was part-time and just filled in because the dietary department was very short of both cooks and dietary aides. She reported due to the lack of dietary staff she had worked with nursing assistants (NA)s who worked on the nursing unit and then helped in the kitchen, but had no training for the kitchen or to work as a dietary aide. Interview on 3/27/24 at 3:47p.m., with the DON reported she had been directed to assist in the dietary department due to lack of staff. She reported she was shown how to run the dishwasher, but had no idea about the temperature requirements, sanitation, or problem solving with the process. The DON reported there had also been nursing assistants who had to help in the kitchen due to staff not showing up, and she was not aware of any specialized training provided. Interview on 3/27/24 at 4:34 p.m. with the assistant dietary manager (ADM) reported the facility had been very short of both dietary aides and cooks over the past few months and she had been helping in dietary as needed. The ADM reported she had ServSafe Certification (program developed by the National Restaurant Association to help set a standard for food safety training in the industry). The ADM reported multiple persons had been assisting in the dietary department including nursing assistants who were not previously trained to work in the dietary department.	F 801		

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Interview on 3/28/24 at 3:37 p.m. with the dietary manager (DM) reported when she had taken the position as DM, she had developed an orientation process but had not reviewed to ensure staff working in the department were oriented and/or competent in their assigned duties. The DM identified she had provided some verbal direction to TMA-A but had not completed any documentation, nor was she aware of any orientation provided to additional non dietary staff that had assisted in the department.

Observation of the DM on 3/27/24 and 3/28/24 at various times was of her coughing and sneezing while working both in and out of the dietary department. She was observed wearing a mask, which was covering her mouth, but not her nose. When questioned regarding persons working when ill, DM reported she had stayed home when she was ill the previous week but did not have a fever and needed to cover shifts. DM reported she had been asked to be tested for Influenza-A but declined and reported that was what residents and other staff had, so she didn't feel she needed to spend the money to be tested.

Interview on 3/29/24 at 12:53 p.m. with the registered dietitian (RD) reported she was aware the facility was having issues with staffing, and had an outbreak of Influenza-A. She reported she came to the facility at least 2 x monthly and had been checking more closely since the outbreak. She reported her expectation for infection control practices to be followed for both staff and residents who had any illness. She also voiced her expectation for orientation/training to be provided to any staff persons who assisted with meal preparation or serving.

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Review of the January 18, 2022, policy Influenza, Prevention and Control of Seasonal listed Surveillance-when influenza was present in the community or there was one laboratory-confirmed case in the facility, active daily surveillance was to be performed for all new and current residents, healthcare personnel and visitors. Training/Education was to include methods of influenza transmission, signs/symptoms, complications and risk factors for complications, self-assessment and reporting, review of precautions, appropriate use of personal protective equipment (PPE). Staff with acute respiratory symptoms without fever may still have influenza and are evaluated by the infection preventionist to determine appropriateness of contact with residents.

Review of the December 9, 2021, policy preventing foodborne illness-food handling identified all employees who handle, prepare, or serve food were to be trained in practices of safe food handling, and prevention of foodborne illness. Employees were to demonstrate both knowledge/competency in practices prior to working with food or serving food to residents.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/24/24

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State

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F 812	Continued From page 13 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique during 1 of 1 meal service. This had the potential to affect all 23 residents in the facility. Findings include: Observation on 3/29/24 beginning at 11:50 a.m. and extending through the noon meal service identified multiple incidents of potential cross contamination and issues with hand hygiene. Cook-A applied gloves and arranged serving utensils on top of the covered steam table pans. He then picked up tray cards from a table behind the steam table, found the card he was looking for, placed it onto a tray, picked up a plate and using a spatula in his right hand and his left gloved hand, picked up a piece of fish from the steam tray, placed it onto the plate, folded back the foil over the scalloped potatoes, placed a scoop of potatoes onto the plate, used his right gloved hand to push some potatoes back onto the plate from the edge, retrieved a slice of bread from the open bag on the side of the steam table	F 812	Cook A was in-serviced on 04/02/2024 when to use single use gloves. All other dietary staff members were in-serviced on hand hygiene on 3/29/2024. There were no ill effects experienced by the residents for this deficient practice. For future meal delivery, dietary staff will wear single use gloves at the appropriate times per facility policy. Dietary staff were in-serviced on the Bare Hand Contact with Food and Use of Plastic Gloves policy with emphasis on item #6 that anytime a contaminated surface is touched, the gloves must be changed. Dietary Manager and/or designee is responsible for compliance. Audits on hand hygiene before donning gloves and after touching contaminated surfaces will begin 2x week for 3 weeks, weekly x2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendations.	

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F 812	Continued From page 14 and placed it on top of the plate of food, picked up a cover, placed over the food, went to the side of the serving area picked up a coffee cup, poured coffee from the carafe, returned to the tray, carried the tray into the dining room, where he served the food to a seated resident. (Staff assisting in the dining room were also observed pouring hot water and coffee from the same carafes). He then returned to the steam table to repeat the process. Each time he served a piece of fish, he used the spatula with his right hand, and reached into the steam pan with his left hand to support the piece of fish onto the plate. He repeated this process multiple times, touching plates, trays, tray cards, glasses, cups, and containers of liquids, in addition to pieces of fish and bread with his same gloved hands. At 12:15 p.m. cook-A retrieved a plate of salad and desert from the tray located beside the steam table for an employee, then removed his gloves, washed his hands, and reapplied gloves. He went to the table containing the tray cards, picked up a card, reviewed, picked up a small round bowl containing ground meat, placed it in the microwave, turned the dial to start, waited 20 seconds, removed the bowl and dumped the ground meat onto a plate, using his gloved hand, spread the meat into a flattened shape, when asked about temperature of the meat, cook-A retrieved a thermometer, used his left gloved hand to push the meat into a pile to check the temperature, which was 138 F. He then used his left gloved hand to push the meat back into the bowl and put back into the microwave to reheat. When he took it from the microwave, it had spilled out over the sides of the bowl. Cook-A rechecked the temperature and it was at 160 F. He then dumped it back onto the plate, dished the potatoes and vegetable onto the plate and took to	F 812	Compliance: 4/24/2024	

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F 812	Continued From page 15 the dining room where he placed it in front of a resident. He returned to the serving area, changed his gloves which were soiled with the ground meat. He picked up a glass from the dish rack of glasses with his gloved right hand, observed a gel like substance on the glass, placed it onto the tray of soiled items, picked up a second glass which was also soiled, disposed of that glass, and retrieved a third from the same rack, which he filled with orange juice and placed on a tray. Without changing his gloves, cook-A retrieved a card and indicated it listed choice of deli meat. He stated he was not certain what this meant and would need to check with ADM. Cook-A carried the card, walked across the hall to the keypad kitchen door, keyed in the code, opened the door and walked into the kitchen. The ADM was not present, so he returned, opened the kitchen door, same gloved hands, returned to the steam table, dished another plate with fish, potatoes, vegetable, and bread, same process touching items with same gloved hands. Served the plate to a resident in the dining room. He then stated he would ask the resident what he meant by Deli meat. Cook-A went over to the resident seated in a wheelchair, placed his right gloved hand on the handle of the wheelchair and resident's back and asked him about his meat choice. With no glove change of hand hygiene, cook-A, again crossed the hall to the kitchen, opened the door via the keypad, entered the kitchen, crossed to the walk-in cooler, which he opened with his gloved hands, entered, and returned with a plastic bag containing slices of precooked, deli style ham. He placed the package of ham on the table in the kitchen, looked around, then picked up the package containing the ham, same gloved hands, opened the kitchen door and exited returning to the steam	F 812		

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F 812	Continued From page 16 table where he placed the bag of ham on the front counter of the steam table, opened the package, reached into the package with his left gloved hand and took out several slices of ham which he held in his left gloved hand, picked up a pair of scissors from the cart beside the steam table and cut the ham into pieces, placing them onto a plate. When finished cutting up the meat, he returned the scissors to the cart, placed the package of meat on the cart containing salads for staff meals. Cook-A added potatoes to the plate, filled a glass with juice and a coffee and served the meal to the resident. He then returned to the steam table and continued dishing meals. 12:25 p.m. cook-A continued the same process, but now using his same gloved hands to pick up the fish from the steam table and place onto plates, then dish other foods with scoop, and use hand to place a slice of break on top of the plate. Cook-A took a second bowl of meat and a bowl containing potatoes, heated in the microwave, and checked temperature which was at 130 F. He returned the bowls to the microwave and reheated this time with temperature of 165 F. Used his gloved hands to arrange ground meat on plate, dumped potatoes onto plate, and served to resident in dining room. Cook-A picked up a slice of bread with same gloved hand, retrieved the scissors from the cart and cut off the bread crust before placing the slice of bread on top of the plate of food, which was then served. 12:50 p.m. cook-A reported everyone had been served. When interviewed he reported he had never been told he needed to check the temperature of pureed or mechanical foods, but just heated and served. When asked how he knew how much food was contained in the bowl of mechanically altered foods, he replied it was the same as what was served on the seam table,	F 812		

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F 812	Continued From page 17 but he didn't measure it. The small bowls of food were on the table beside the steam table until they were heated and served. When asked about hand hygiene and glove changes, repeated he should have changed his gloves more frequently, and did not reply when asked about touching food with his gloved hands. Interview at 12:55 p.m. with Cook-A reported he had never been oriented to the kitchen when he started but had worked for a local food service company that had very strict protocols for food safety, so he was comfortable with his job duties. Interview on 3/29/24 at 2:30 p.m. with the DM identified her expectation that dietary staff followed infection control practices with glove changing between tasks, and if they touched a food item. She reported cook-A was employed when she took over in the kitchen and she had not reviewed his training or assessed his competency with food service tasks. Interview on 3/29/24 at 3:50 p.m. with the registered dietitian (RD) identified her expectation for all staff to be trained and follow food safety and hand hygiene guidelines. She reported it was not acceptable to touch food and potentially contaminated services without performing appropriate hand hygiene and glove changes before returning to serving food. Review of the December 9, 2021, policy preventing foodborne illness-food handling identified all employees who handle, prepare, or serve food were to be trained in practices of safe food handling, and prevention of foodborne illness. Employees were to demonstrate both knowledge/competency in practices prior to working with food or serving food to residents.	F 812		

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F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide adequate and specialized rehabilitative services of occupational therapy (OT) and physical therapy (PT) therapy according to residents individualized needs based on a comprehensive assessment for 2 of 2 residents (R2 and R10) who had orders for physical therapy (PT) and occupational therapy (OT). Findings include: R2's diagnoses included bilateral osteoarthritis, sepsis, pressure wound on buttocks and weakness.	F 825	R 1 and R 2 have discharged from the facility. All current residents who are currently receiving therapy treatments, their frequency of treatment was reviewed and any missed visits, the MD will be updated, and the MD response will be recorded in the resident electronic medical record. Future residents who receive therapy services, their frequency of treatment will be based from hospital and facility record review, initial therapy screen, resident input and physician signed orders. Director of Rehabilitation was in-serviced on the Scheduling of Therapy Services	4/24/24

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F 825	Continued From page 19 R2's admission Minimum Data Set (MDS) dated 3/11/24, indicated R2 was admitted to the facility on 3/5/24, did not have cognitive impairment, did have impairment to range of motions (ROM) to one upper extremity and both lower extremities, used a walker and wheelchair. R2 was dependent with lower body dressing and putting on/off footwear, personal hygiene and sit to lying position. R2 required maximal assist with toilet hygiene, shower/bathing, rolling side to side in bed, sit to stand position, and transfers. Partial assist with upper body dressing, ambulating 10 feet and wheeling wheelchair 50 feet with two turns. R2 was receiving OT with a start date of 3/7/24, and PT with a start date of 3/11/24. R2's admission physician orders dated 3/5/24, included OT and PT both to eval and treat. R2's Activities of Daily Living (ADL) care plan dated 3/6/24, R1 is extensive assist of one staff for bathing/showering, dressing and toilet use. R2 requires set up for personal and oral hygiene. Independent with bed mobility, with the use of bedrails and trapeze. R2 independent in room per therapy and extensive assist of one staff, front wheeled walker, gait belt and appropriate footwear for ambulation out of room. R2's OT evaluation and plan of treatment dated 3/7/24, ordered a frequency of three to five times per week for eight weeks to improve resident's rehab potential, maximize resident's rehab potential, increase independence with activities of daily living (ADLs), maximize independence with ADL's, and facilitate independence with ADLS in order to enhance resident's quality of life by improving ability to return to prior living situation, certification period of 3/7/24 to 4/5/24.	F 825	with emphasis on interviewing the resident and consult with the MD the type of treatment to be administered. The Administrator and/or designee is responsible for compliance. Audits on resident admission date, date therapy services were initiated, therapy treatment plan frequency and therapy end date will begin 2x week for 4 weeks then monthly to ensure sustained compliance. Audits will be reviewed by the Administrator and the Administrator will take the audit results to QAPI for review and recommendation. Compliance: 04/24/2024	

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Review of R2's OT notes indicated R2's evaluation was completed on 3/7/24. According to the record R2 was provided services on 3/8/24, 3/11/24, 3/15/24, 3/18/24, 3/20/24, 3/22/24, and 3/25/24. Did not consistently meet the three to five times per week per the ordered treatment plan.

R2's PT evaluation indicated R2 was referred to therapy status post hospitalization due to functional decline at home. The plan of treatment dated 3/11/24, directed a frequency of 8 times per period of 4 weeks, intensity of daily with certification period of 3/11/24 to 4/9/24. R2's short term goals included:
- Patient will safely perform bed mobility tasks with minimum assist without use of siderails in order to prepare for gait activities (Target 3/24/24). Prior level of function was independent; baseline on 3/11/24 was moderate or modified assist.
-Patient will safely perform functional transfers with contact guard assist in order to return to prior level of functional abilities. Prior level of function was independent; baseline on 3/11/24 was minimal assist.
-Patient will safely ambulate on level surface 250 feet using FWW with stand by assist with normalized gait patter 100% of the time to increase independence in the facility. Prior level of function was independent; baseline on 3/11/24 was contact guard assist.

Review of R2's PT notes identified from 3/11/24 to 3/29/24, R2 received therapy on 3/11/24 and on 3/29/24.
-R2's Treatment Encounter Note dated 3/11/24, indicated the session was completed by the

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physical therapist (PT)-B. The note included Gait training: gait training to normalize patter, PT provided minimal assist during ambulation for patient safety. Patient ambulated 1 x 250 feet, 1 x 100 feet with FWW. Will progress as able. The note did not identify session duration time.

-R2's Treatment Encounter Note dated 3/29/24, indicated the session was completed by PT-C. The note included Gait training to improve functional mobility and return patient to previous level of function. Patient ambulated 250 feet with ww (sic) stand by assist with cues for postural alignment and energy conservation techniques. Seated lower extremity exercises in all joints/planes with "YTB" in order to improve stability during functional ability, forward and backward ambulation to promote ankle strategies and self righting ability. Cues for pacing when ambulating backwards with contact guard assist.

All physical therapy notes and evaluations were requested. The requested documentation received from 3/11/24 through 3/29/24 did not include an evaluation of goal status and/or effectiveness of only having physical therapy for two therapy sessions in 18 days.

R10's diagnoses included stroke with weakness to one side of his body.

R10's admission MDS dated 3/7/24, indicated an intact cognition, with ROM impairment on one side of his body, used a wheelchair and walker. R10 was dependent with toilet hygiene, lower body dressing, putting on/off footwear. R10 required substantial assist with upper body dressing, personal hygiene, sitting to lying position, all transfers, and walking 10 feet. R10

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required moderate assist with oral hygiene, turning side to side in bed, and lying to sitting position. R10 was independent with wheeling 50 feet with two turns and wheeling 150 feet once in wheelchair. R10 received OT with a start date of 3/3/24 and PT with a start date of 3/5/24.

R10's admission physician orders dated 3/1/24, cardiac discharge instructions indicated that R10 should have as much activity as possible, but pulse should remain below 110 for 1 month following his procedure on 2/28/24. Please ambulate R10 to meals with front wheeled walker (FWW)/gait belt, assist of two staff, while monitoring his pulse and oxygen levels, followed by a wheelchair. PT to evaluate and treat. OT to evaluate and treat.

R10's PT evaluation indicated R10 required physical therapy related to status post hospitalization due to cervical cord compression, cervical decompression surgery, angiogram procedure, and functional decline. The plan of treatment dated 3/5/24, indicated frequency of one to five per week for duration of four weeks, intensity was identified as daily with certification period of 3/5/24 to 4/3/24. PT goals were as follows:
-Patient will safely perform functional transfers with contact guard assist in order to facilitate increased participation with functional daily activities (Target date 3/18/24) Previous level of performance was independent; baseline on 3/5/24 was minimal assist.
-Patient will safely ambulate on level surfaces 200 feet using FWW with Min assist 100% of the time while maintaining good balance to allow patient to get to bathroom with decreased assistance (Target date 3/18/24) Previous level of

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F 825	Continued From page 23 performance was unlimited distance independently; baseline on 3/5/24 was 200 feet with moderate assist. -Patient will increase dynamic standing balance to fair- and using righting reactions 100% of the time to right self in order to reduce the risk for falls (Target 3/18/24). Previous level of function was normal; baseline on 3/5/24 was poor+ moderate assist and upper extremity support to stand and reach ipslaterally without LOB; unable to weight shift. -Patient will safely perform functional transfers with independely in order to facilitate increased participation with functional daily activities (Target 4/3/24). Previous level of function was independent; Baseline was on 3/5/24 was minimal assist. -Patient will safely ambulate on level surfaces 200 feet using FWW with modified independence 100% of the time while maintaining good balance to allow patient to get to bathroom with decreased assistance (target date 4/3/2024). R10's progress notes identified between 3/5/24 and 3/28/24, R10 completed only three physical therapy session on 3/7/24, 3/11/24, and 3/28/24. -PT Encounter Note dated 3/7/24, indicated physical therapy assist (PTA) completed the session. The note included R10 ambulated 200 feet with contact guard assist, was fatigued after 15 feet, and became unsteady. Patient does ambulate with ataxic gait pattern at times. Patient performs bed mobility with modified independence supine to sit. The note did not identify time duration of the visit. -PT Encounter Note dated 3/11/24, indicated physical therapist (PT)-A completed the session. The noted included Patient implemented gait training to progress functional ambulation ability	F 825		

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F 825	Continued From page 24 and independence. Patient required contact guard assist during ambulation for safety. R10 ambulated 2 x 400 feet with FWW. Will progress as able. The note did not identify time duration of the visit. -PT Encounter note dated 3/28/24, indicated PT-B completed the session. The note included PT provided stand by assist during ambulation for safety. Gait training; gait training to normalize gait pattern, directional changes, training strategies to safely maneuver around obstacles and self correction during task performance. Patient ambulated 4 x 200 feet with 4WW. Continued skill PT services necessary to progress to modified independence with 4WW. The note did not identify time duration of the visit. All physical therapy notes and evaluations were requested. The requested documentation received from 3/5/23 through 3/28/24 did not include an evaluation of goal status and/or effectiveness of only having physical therapy once per week or the 3 (three) therapy sessions. During an interview on 3/27/24 at 5:15 p.m., director of nursing (DON) indicated that she started a walking program on or around 3/15/24, because facility did not have adequate therapy services in place and feared the residents would decline in their ability to walk and maintain strength. DON further indicated she was unsure if there was a decline in any residents functional ability to ambulate, however if they were not getting services consistently there was a risk they would decline or lose mobility. During an interview on 3/28/24 at 12:14 p.m., physical therapist (PT)-A, stated he was on a as needed basis (PRN) and attempted to get to the facility once a week. PT-A stated that he did not	F 825		

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know who was providing the PT sessions when he was not in the building. There was only one intermittent therapy assistant and was not aware of what the PTA's schedule was. PT-A stated the lack of having a full time PTA was hurting the residents because although there may not be an overall decline the patients were not progressing like when the therapy department had more help. Further though there had been some residents that had been discharged from therapy that he feels should not have been. PT-A could not think of specific examples. PT-A indicated the facility had been doing "teletherapy" and did not like doing things that way, he preferred to see the patients in person. PT-A indicated he did not think the facility had been admitting resident who required skilled care because there was not an adequate number of staff to provide the necessary services.

During an interview on 3/28/24 at 4:35 p.m., director of therapies (DOR)-A, stated that he was a Certified Occupational Therapy Assistant (COTA). DOR-A stated he was at the facility 3-5 times per week to provide occupational therapy services. DOR-A explained the facility switched therapy companies on 2/1/24. The PT-A only comes in about once a week with no set day. DOR-A would inform PT-A when new residents were admitted to the facility. DOR-A confirmed that the facility did not employee a full time PTA and PTA had not been at the facility for about 3 weeks. DOR-A further indicated that the facility was actively working on hiring physical therapist and physical therapy aides to meet the residents' needs.

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F 825	Continued From page 26 Request for policies for therapy was requested but not received. Facility Assessment last reviewed by the quality assurance committee identified the facility provided PT/OT services. Part 3: Facility Resources needed to provide competent support and care for our resident population every day and during emergencies included: "Therapy Services (e.g., OT, OTA, PT, PTA...)"	F 825		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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,	F 880		4/24/24

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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 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.

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This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to implement infection control practices in accordance with Centers for Disease Control (CDC) recommendations to prevent and/or mitigate the risk of the spread of communicable disease Influenza such as utilization of appropriate personal protective equipment (PPE), appropriate hand hygiene, preventing ill staff from working, implement active symptom screening for residents and staff, and providing staff ongoing education during outbreak. The facility's failures resulted in an Influenza A outbreak that effected 9 out out of 23 residents and had the potential to effect the remaining residents, visitors, and staff.

Findings include:

During entrance conference on 3/27/24, State Agency was made aware of an Influenza A outbreak in the facility. The outbreak started that began on 3/16/24, effected 9 out of 23 residents. Five residents were on isolation precautions at the start of the survey. and is continuing and affecting nine out of 23 residents. Five residents (R7, R11, R13, R14 and R15).

Review of the facility's resident influenza A and isolation line listing, identified the following:
R3 tested positive on 3/16/24, and ended isolation on 3/23/24,
R6 tested positive on 3/17/24, and ended isolation on 3/24/24,
R16 tested positive on 3/18/24, and ended isolation on 3/25/24,
R9 started isolation on 3/18/24, and ended isolation on 3/25/24,

F 880

All facility residents who experience influenza have all recovered and precautions have been removed. The employee illness line listing from survey exit until present was updated. Influenza reporting was completed on 4/18/2024. Future resident illnesses, residents will be placed in Transmission Based Precautions, employees who are ill will be restricted from the facility until symptoms resolve and for reportable infections, notification will be made to the state agency per our facility policy.
Facility staff will be in-serviced on the Employee Pre/Post Respiratory with emphasis on item #1 that employees must notify the Infection Preventionist of reportable conditions and will be notified not to work until symptoms resolve. In addition, the staff were in-serviced on the hand hygiene and PPE Policies with emphasis on employees using the appropriate PPE when entering resident rooms and the licensed nurses were in-serviced on observing residents for s/s that may indicate infection. If outbreak is suspected, they will alert the infection preventionist or DON.
Director of Nursing and/or designee is responsible for compliance.
Audits on employee illness line listing and infection preventionist supplemental notes for employee return will begin weekly x 2 weeks, then monthly to ensure sustained compliance.
Audit results will be reviewed by the Executive Director and the Executive

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F 880	Continued From page 29 R12 started isolation on 3/19/24, symptomatic but tested negative, R4 started isolation on 3/19/24, symptomatic but tested negative, R15 tested positive 3/20/24, and ended isolation on 3/27/24, R14 tested positive on 3/21/24, and ended isolation on 3/28/24, R11 tested positive on 3/21/24, and ended isolation on 3/28/24, R7 tested positive on 3/22/24, and ended isolation on 3/29/24, R13 tested positive on 3/22/24 and ended isolation on 3/29/24. In review of the facility's IC surviellance program activities, it was not evident employee illness line listing was completed, no record of employee or resident active screening, and not evident audits and education were completed after Influenza outbreak. During an interview on 3/28/24 at 10:19 a.m., assistant director of nursing (ADON) who identified herself as the infection preventionist (IP) and responsible for the facility's infection control (IC) surveillance program. IP reviewed active surveillance line listing and IC program activities. IP stated line listing for residents identified nine residents; R3 who resided on the east hallway was the first positive case on 3/16/24. Then on 3/17/24, the virus spread to the west hallway and four more residents R6 and R16 tested positive/R4 and R12 were symptomatic but tested negative. On 3/20/24, three more residents (R15, R14, R11) tested positive. R7 who resideded on the west hallway tested positive on 3/22/24 and R13 who resided on the east hallway tested positive on 3/22/24. IP	F 880	Director will take audit results to QAPI for review and recommendations. Compliance: 4/24/2024	

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F 880	Continued From page 30 indicated consistent staffing was attempted however was not followed by NAs. IP reported active symptom screening for residents was never implemented because she had not been aware of the CDC guidance and recommendation. IP reviewed the illness tracking for staff, she confirmed tracking for staff was not completed and had not been completed in real time. IP explained staff would not communicate illnesses with her and the department managers would not communicate ill calls. IP would update the form when she became aware, sometimes days later. IP stated the facility had not implemented active screening for staff, she was unaware of that recommendation by the CDC as a prevention strategy. IP referenced the staff line listing on 3/18/24, which identified the dietary manager (DM)-A came in sick to work. IP had told her to go home because she did not look well however, DM-A did not go home, continued to work in the kitchen with residents food, refused to get tested, and shortly there after mulitple dietary staff became ill with the flu. IP explained audits that would identify causal factors of spread and to identify staff education to prevent or mitigate the risk of further spread of the virus were not completed because she was not afforded enough time. IP stated she had continously spent a lot of time out on the floor providing in the moment education to direct care staff because she had identified staff were not washing their hands nor using PPE appropriately. IP voiced frustration because despite ongoing constant reminders and eduation staff continued to not practice appropropriate use of PPE or hand hygiene. IP explained she thought the influenza spread was related to several factors including staff not performing appropriate hand hygiene, wearing appropriate PPE and staff coming in sick to work.	F 880		

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F 880	Continued From page 31 Furthermore, IP did not know that she had to report this influenza outbreak to the state agency (SA). Review of the facility's employee line listing for March 2024, identified the following: -DM-A had symptoms of sore throat, nasal congestions, diarrhea, and cough: Symptom start date 3/2/24, illness reported on 3/3/24, DM-A's lat shift worked prior to symptom onset was 3/1/24. DM-A returned to work on 3/5/24. -Nursing assistant (NA)-C had symptoms of fever that started on 3/17/24. NA-C reported symptoms on 3/18/24, NA-C's last shift worked prior to symptoms was 3/16/24, and returned to work on 3/21/24, -Licensed practical nurse (LPN)-A symptoms of cough and nasal congestion started on 3/17/24. LPN-A reported symptoms on 3/17/24 and worked on 3/17/24. LPN-A returned to work on 3/20/24. LPN-A was treated with Tamiflu (antiviral used to treat influenza), -DM-A had resumption of symptoms with headache and nasal congestion that started on 3/18/24. DM-A reported symptoms on 3/18/24 and worked. DM-A's last worked shift prior to symptom onset was 3/16/24. DM-A returned to work on 3/20/24, -NA-C symptoms of headache and fever, started on 3/18/24, reported on 3/18/24, last shift worked 3/16/24, and returned to work on 3/22/24, -DA-D symptoms of cough, headache, sore throat, and nasal congestion, started on 3/20/24, reported on 3/20/24, last shift worked 3/19/24, and returned to work on 3/22/24, -NA-E symptoms of chills and headache, started on 3/20/24, reported on 3/20/24, last shift worked 3/19/24, and returned to work on no date listed, -C-B symptoms of cough, fever, headache, nasal	F 880		

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F 880	Continued From page 32 congestion, started on 3/21/24, reported 3/21/24, last shift worked 3/21/24, and returned to work on 3/27/24 -ADON symptoms of chills, cough, fever, body aches, started on 3/22/24. Reported on 3/22/24, last shift worked 3/21/24 and returned to work on 3/27/24, -AA symptoms of runny nose and nasal congestions, started on 3/26/24, reported 3/26/24, last shift worked 3/26/24 and returned to work on 3/27/24, symptoms lasted less than 24 hours. All above employees tested negative for COVID 19. During an observation on 3/27/24 at 1:21 p.m., trained medical aide (TMA)-B was observed in R13's room who was droplet contact precautions without PPE on. There was a sign posted on the door that directed the use of gloves, gown for contact precautions and gown, gloves and face mask for droplet precautions. TMA-B was not wearing any PPE when observed walking away from R13 to exit the room. TMA-B confirmed R13 had influenza A and TMA-B should have been wearing a mask at least. During a tour of facility on 3/27/24 at 4:30 p.m. observed five residents (R7, R11, R13, R14 and R15) had Contact and Droplet isolation signs on the doors of their room; all of the room doors were open. At 4:35 p.m., nursing assistant (NA)-J and NA-F were observed going in and out of resident's room, including those on isolation, providing cares to different resident's without changing their facial masks, R2-(on isolation or already had?), R11, R14 and R16 (on isolation or already had?).	F 880		

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F 880	Continued From page 33	F 880		

Observation of the DM on 3/27/24 and 3/28/24 at various times was of her coughing and sneezing while working both in and out of the dietary department. She was observed wearing a mask, which was covering her mouth, but not her nose. When questioned regarding persons working when ill, DM reported she had stayed home when she was ill the previous week but did not have a fever and needed to cover shifts. DM reported she had been asked to be tested for Influenza-A but declined and reported that was what residents and other staff had, so she didn't feel she needed to spend the money to be tested.

During an observation on 3/28/24, at 10:15 a.m. all five residents who were on contact precautions had their doors open.

During an observation on 3/28/24 at 10:17 a.m., R14's room had a sign on the door that directed the use of droplet precautions. R14 laid in bed resting peacefully without evidence of agitation or restlessness. NA-A was observed going into R14's without any PPE on. NA-A walked over to R14 leaned down to talk into R14's ear, inches away from his face and touched R14's bed. NA-A then walked out of R14's room without performing hand hygiene. When questioned about hand hygiene and PPE usage, NA-A raised her hands in the air and confirmed R14 required droplet precautions and staed, "No I did not put on a gown or mask". NA-A quickly turned and walked down the hallway into another resident's room who was on hospice, had not had Influenza A, and did not have symptoms of illness. NA-A had not performed hand hygiene prior to entering this residents room. When NA-A walked out of the room she again did not perform hand hygiene.

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F 880	Continued From page 34	F 880		

Review of facility policy Influenza, Prevention and Control of Seasonal, indicated:
-section symptomatic residents and visitors, 6b: providing instructions before visitors enter residents' room, on hand hygiene, limiting surfaces touched and use of PPE while in resident's room.
-Under section symptomatic healthcare workers, 2. Staff who develop fever and respiratory symptoms are: a. instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor and the IP and/or designee before leaving work; b. excluded from work until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines). Those with ongoing symptoms will be considered for evaluation by the IP and/or designee to determine appropriateness of contact with residents.
-under infection precautions, 1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven days after the illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.

Review of facility policy Influenza, Prevention and Control of Seasonal, indicated:
-section symptomatic residents and visitors, 6b: providing instructions before visitors enter residents' room, on hand hygiene, limiting surfaces touched and use of PPE while in resident's room.
-Under section symptomatic healthcare workers, 2. Staff who develop fever and respiratory symptoms are: a. instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor

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F 880	Continued From page 35 and the IP and/or designee before leaving work; b. excluded from work until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines). Those with ongoing symptoms will be considered for evaluation by the IP and/or designee to determine appropriateness of contact with residents. -under infection precautions, 1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven days after the illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility determined the	F 882	The facility assessment was updated to include time needed for the IP to perform	4/24/24

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F 882	Continued From page 36	F 882		

required time needed for the infection preventionist based on the facility assessment, resident census and characteristics, and during communicable disease outbreaks. Further failed to ensure the IP was afforded adequate time and resources to effectively execute infection control program activities to prevent and/or mitigate the risk of infectious spread.

Findings include:

SEE F812: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique during 1 of 1 meal service. This had the potential to affect all 23 residents in the facility.

SEE F880: Based on observation, interview and document review, the facility failed to implement infection control practices in accordance with Centers for Disease Control (CDC) recommendations to prevent and/or mitigate the risk of the spread of communicable disease Influenza such as utilization of appropriate personal protective equipment (PPE), appropriate hand hygiene, preventing ill staff from working, implement active symptom screening for residents and staff, and providing staff ongoing education during outbreak. The facility's failures resulted in an Influenza A outbreak that effected 9 out out of 23 residents and had the potential to effect the remaining residents, visitors, and staff

During entrance conference on 3/27/24, state agency (SA) was made aware of facility outbreak of Influenza A, with nine out 23 residents diagnosed with Influenza A. Five residents remained on isolation.

and implement infection control surveillance based on resident population, and/or during times of communicable disease outbreaks. The Infection Preventionist role will continue to utilize facility infection control policies, the Minnesota Department of Health ICAR program along with CDC guidelines.
Facility will also request ICAR visit to review infection control policies and procedures along with environmental review.
The future Infection Preventionist will be in-service on the Infection Prevention Policies and Procedures with emphasis on facility surveillance and available tools and resources available from the facility policies and other outside resources.
Director of Nursing and/or designee is responsible for sustained compliance.
Audits on facility surveillance (resident laboratory results, antibiotic initiation, document review) will begin 2x week for 3 weeks, weekly x 2 weeks then monthly to ensure sustained compliance.
Audit results will be reviewed by the Executive Director and the Executive Director will take audit results to QAPI for review and recommendations.
Compliance: 4/24/2024

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F 882		F 882		

Continued From page 37

During an interview on 3/28/24 at 10:19 a.m., IP stated that she did not have a set number of hours to spend on infection control, was not aware of how many hours she was supposed to dedicate for infection control activities, and had not logged any hours. IP guessed since her employment started in November of 23, she has "probably" only worked a total of 40 hours on infection control activities. IP stated she also was the assistant director of nursing (ADON). In the ADON role she assisted with meeting residents needs, answering call light, she managed all the wound, responsible for staff education and orientation of new employees. IP stated she strongly felt enough time had not been dedicated to infection control; IP explained she had not implemented active symptom screening for residents and staff after the Influenza outbreak. IP did not complete any infection control audits or document staff education she had provided in the moment because there was not enough time. IP was not aware of how she was supposed to complete other job tasks that she was responsible for and dedicate necessary hours to infection control that would have been beneficial in preventing further positive cases of influenza.

Review of the infection prevention program policies titled Surveillance for Infections stated the IP will conduct ongoing surveillance for healthcare-associated infections (HAI's) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. The policy did not identify required time needed for the IP to perform and implement the facilities infection surveillance program based on a comprehensive assessment

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F 882	Continued From page 38 of the resident population and/or during times of communicable disease outbreaks. Review of the Facility Assessment last reviewed by the quality assurance committee on 7/28/23, did not identify required time needed for the infection preventionist based on the resident population. IP job description for IP was asked for but not received.	F 882		

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2 000	Initial Comments	2 000		

*****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 3/27/24 through 3/29/24, a complaint 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 licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed. H53782350C (MN101891, MN101946), H53782602C (MN102025, MN101968), H53782563C (MN101971), H53782564C (MN100218), and H53782565C (MN101970), with a with a licensing orders issued at (0265, 0490, 0985, 1015, 1390, 1510). 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 surveyor ' s 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 14-01, available at <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	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to	2 265		4/24/24

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2 265	Continued From page 3 begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide required timely notifications for 1 of 2 residents (R4) who experienced falls. Findings include: R4's 3/17/24 Significant change Minimum Data Set (MDS) assessment identified she was on hospice services (3/7/24), her cognition was intact, and she required supervision and assistance with her Activities of Daily Living (ADLs). R4 had diagnoses of dementia, malnutrition, history of falls and urinary incontinence. R4 experienced 3 documented falls in the month March and family members expressed their concern regarding supervision and factors contributing to her falls. 1.) 3/11/24 at 1:45 p.m. R4 was found lying on the floor in her room with her walker next to her. Blood was noted on the floor and she had a large lump and a laceration on the back of her head. Additional minor injuries included skin tears on her left hand, right forearm, and ankle. R4's record indicated the family was notified. 2.) 3/20/24 at 5:00 p.m. R4 was walking in the hall with her walker and had a gait belt around her waist. An unidentified staff person was walking	2 265	Corrected	

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2 265	Continued From page 4	2 265		

behind R4 with no contact on resident's gait belt. The report identified the walker got ahead of her, she lost her balance and fell forward landing on her knees and obtained a moon shaped cut on her left knee. There was no documentation on either the report or resident record of notification of the director of nursing (DON).
3.) 3/21/24 at 5:55 p.m. R4 was discovered lying on the floor in front of her chair with a large hematoma (bruise) noted on the left side of her forehead above her left eye, below the hair line. Further assessment identified a small skin tear on her left elbow. There was no documentation on either the Incident report or resident record of notification of the responsible party or family members.

Interview on 3/27/24 at 1:54 p.m., during R4's care conference with multiple family members and the hospice registered nurse (RN) identified R4 had been a resident at the facility since March of 2021. FM-A with agreement from other FM's in attendance reported they had not had concerns with R4's care and safety until the past month when she experienced 3 falls. Family member (FM)-A (designated for notification) reported she was not notified by the facility and was not aware of R4's fall on 3/21/24. FM-A reported her concern with not receiving notification, especially with the amount of facial injury and questioned if there were additional incidents she had not been notified about. She reported R4 would not remember what had happened and the family had depended on the facility to take care of their family member and notify them if there were any areas of concern.

Interview on 3/27/24 at 3:43 p.m., with the director of nursing (DON) reported her expectation for all licensed staff to follow the

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2 265	Continued From page 5	2 265		

Continued From page 5

facility policy for assessment and appropriate notification of the DON, medical provider, and family as soon as possible following an incident. She reported if a fall with no injury occurred during the night and family requested to wait until morning to be notified, that was acceptable. In the instance of R4's fall on 3/21/24 at 5:45 p.m., the family should have been notified once the assessment was completed to determine if they wanted R4 sent to the Emergency department for further evaluation. She also reported staff should have notified her following R4's fall on 3/20/24 and would need to investigate further.

Review of the October 4, 2021 Falls-Clinical Protocol Steps in the Procedure identified to evaluate for possible injuries, monitor vital signs, position the resident comfortably if no injury, and document relevant details. Notify the resident's attending physician and family in an appropriate time frame. Documentation recorded in the medical record was to include details of the fall, assessment data, any interventions implemented, notification of physician and family and signature and title of the person recording the data.

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing (DON), or designee could develop and implement measure to ensure timely notification to the physician. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The facility should perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for

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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) COMPLETE DATE
2 265	Continued From page 6 further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 490	MN Rule 4658.0270 Withdrawal of Funds from the Account Upon the request of the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident, a nursing home must return all or any part of a resident's funds given to the nursing home for safekeeping, including interest, if any, accrued from deposits. A nursing home must develop a policy specifying the period of time during which funds can be withdrawn. The policy must ensure that the ability to withdraw funds is provided in accordance with the needs of the resident and must specify whether or not the nursing home allows residents to obtain funds to meet unanticipated needs on days when withdrawal periods are not scheduled. A nursing home must notify residents of the policy governing the withdrawal of funds. Funds kept outside of the nursing home must be returned within five business days. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents had access to their personal funds upon request for 1 of 1 resident (R5) reviewed. This had the potential to effect 14 residents who utilized a personal funds account.	2 490	Corrected	4/24/24

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2 490	Continued From page 7	2 490		

Findings include:

During an interview on 3/28/2 at 10:19 a.m., R5 stated she was able to access her money only when administration or the business office was open. She could not access her personal funds on weekends or holidays.

During an interview on 3/28/24 at 2:00p.m., licensed practical nurse (LPN)-A indicated if a resident wants funds they have to go to the administrator or the business office manager during business hours.

During an interview and observation on 3/28/24 at 2:26 p.m., the administrator indicated residents do have access to their money after hours and thought there was $30.00 in the medication room in a cash box if a resident requested money. Further indicated all staff should know how to access it. The administrator requested the assistance of LPN-A to gain access to the medication room holding the cash box but had difficulty locating the cash box and the key to open the box. After 5-10 minutes, the keys were located and the cash box was opened to reveal $45.00 cash in the box with the last noted withdrawal of $5.00 on 3/3/2020. LPN-A stated she did not know the cash box was there.

During an interview on 3/28/24 at 4:00 p.m., the assistant director of nursing (ADON) stated the residents only had access to their funds when the administrator or the business office manager were in the facility. ADON indicated she was unaware of any money in the medication room for resident use or how to access it.

The facility's policy titled, Deposit of Resident Funds last updated 8/15/23, indicates resident

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2 490	Continued From page 8 requests for access to their funds should be honored by facility staff as soon as possible but no later than the same day for amounts less than one hundred $100 ($50 for Medicaid residents) and three banking days for amounts of $100 ($50 for Medicaid residents) or more. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and develop a plan to ensure residents have reasonable access to their personal funds, including weekends. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure resident(s) have access to personal funds, including weekends. The results of these audits will be reviewed by the quality assessment committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 490		
2 985	MN Rule 4658.0610 Subp. 1 Dietary Staff Requirements Sufficient personn Subpart 1. Sufficient personnel. The nursing home must employ sufficient personnel competent to carry out the functions of the dietary service. "Sufficient personnel" means enough staff to plan, prepare, and serve palatable, attractive, and nutritionally adequate meals at proper temperatures and appropriate times. This MN Requirement is not met as evidenced	2 985		4/24/24

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2 985	Continued From page 9	2 985		

by:
Based on interview and document review the facility failed to ensure all staff working in the dietary department had training on use of equipment, safe temperatures to ensure food safety and sanitation processes. This had the potential to affect all 23 residents in the facility.

Corrected

Findings include:

Entrance conference on 3/27/24 at 9:15 a.m. with the director of nursing (DON) and administrator identified the facility was having issues with staffing in the dietary department and multiple staff were assisting with meal preparation and clean up. Both the DON and administrator reported they had assisted in the dietary department. The administrator reported she had worked as a dietary aide and assisted with cleanup. The DON reported she had done dishes and assisted with the dining room.

Review of the dietary schedule for March 2024 identified 1 trained medication aide (TMA)-A scheduled as PM (evening meal) cook. Review of the January, February and March 2024 dietary schedules identified TMA-A worked 3 shifts in January 2024, 8 shifts in February 2024, and 9 shifts in March 2024 as the evening cook.

Observation on 3/27/24 at 5:00 p.m., identified TMA-A in the dietary kitchen as the designated cook for the PM shift. She had worked on the nursing unit for the day shift with resident contact and then worked the PM dietary cook shift. Review of TMA-A's education record identified no specialized orientation to the dietary department, nor was there documentation on the electronic RELIAS education of any courses related to dietary management or food safety.

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2 985	Continued From page 10	2 985		

Interview on 3/27/24 at 3:47p.m., with the DON reported she had been directed to assist in the dietary department due to lack of staff. She reported she was shown how to run the dishwasher, but had no idea about the temperature requirements, sanitation, or problem solving with the process. The DON reported there had also been nursing assistants who had to help in the kitchen due to staff not showing up, and she was not aware of any specialized training provided.

Interview on 3/27/24 at 4:34 p.m. with the assistant dietary manager (ADM) reported the facility had been very short of both dietary aides and cooks over the past few months and she had been helping in dietary as needed. The ADM reported she had ServSafe Certification (program developed by the National Restaurant Association to help set a standard for food safety training in the industry). The ADM reported multiple persons had been assisting in the dietary department including nursing assistants who were not previously trained to work in the dietary department.

Interview on 3/28/24 at 3:37 p.m. with the dietary manager (DM) reported when she had taken the position as DM, she had developed an orientation process but had not reviewed to ensure staff working in the department were oriented and/or competent in their assigned duties. The DM identified she had provided some verbal direction to TMA-A but had not completed any documentation, nor was she aware of any orientation provided to additional non dietary staff that had assisted in the department.

Observation of the DM on 3/27/24 and 3/28/24 at

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2 985	Continued From page 11 various times was of her coughing and sneezing while working both in and out of the dietary department. She was observed wearing a mask, which was covering her mouth, but not her nose. When questioned regarding persons working when ill, DM reported she had stayed home when she was ill the previous week but did not have a fever and needed to cover shifts. DM reported she had been asked to be tested for Influenza-A but declined and reported that was what residents and other staff had, so she didn't feel she needed to spend the money to be tested. Interview on 3/29/24 at 12:53 p.m. with the registered dietitian (RD) reported she was aware the facility was having issues with staffing, and had an outbreak of Influenza-A. She reported she came to the facility at least 2 x monthly and had been checking more closely since the outbreak. She reported her expectation for infection control practices to be followed for both staff and residents who had any illness. She also voiced her expectation for orientation/training to be provided to any staff persons who assisted with meal preparation or serving. Review of the January 18, 2022, policy Influenza, Prevention and Control of Seasonal listed Surveillance-when influenza was present in the community or there was one laboratory-confirmed case in the facility, active daily surveillance was to be performed for all new and current residents, healthcare personnel and visitors. Training/Education was to include methods of influenza transmission, signs/symptoms, complications and risk factors for complications, self-assessment and reporting, review of precautions, appropriate use of personal protective equipment (PPE). Staff with acute respiratory symptoms without fever may still have	2 985		

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2 985	Continued From page 12 influenza and are evaluated by the infection preventionist to determine appropriateness of contact with residents. Review of the December 9, 2021, policy preventing foodborne illness-food handling identified all employees who handle, prepare, or serve food were to be trained in practices of safe food handling, and prevention of foodborne illness. Employees were to demonstrate both knowledge/competency in practices prior to working with food or serving food to residents. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure there are sufficient dietary support personnel to safely carry out all of the functions of the food and nutrition services, including preparing and serving of meals in a timely fashion. The facility could update or create policies and procedures, and educate staff on facility scheduled time for meals, preparation and serving of meals within appropriate time frame. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure preparation and serving of resident meals is within appropriate time frame. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 985		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi	21015		4/24/24

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21015	Continued From page 13 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control technique during 1 of 1 meal service. This had the potential to affect all 23 residents in the facility. Findings include: Observation on 3/29/24 beginning at 11:50 a.m. and extending through the noon meal service identified multiple incidents of potential cross contamination and issues with hand hygiene. Cook-A applied gloves and arranged serving utensils on top of the covered steam table pans. He then picked up tray cards from a table behind the steam table, found the card he was looking for, placed it onto a tray, picked up a plate and using a spatula in his right hand and his left gloved hand, picked up a piece of fish from the steam tray, placed it onto the plate, folded back the foil over the scalloped potatoes, placed a scoop of potatoes onto the plate, used his right gloved hand to push some potatoes back onto the plate from the edge, retrieved a slice of bread from the open bag on the side of the steam table and placed it on top of the plate of food, picked up a cover, placed over the food, went to the side of the serving area picked up a coffee cup, poured coffee from the carafe, returned to the tray, carried the tray into the dining room, where	21015	Corrected	

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21015	Continued From page 14	21015		

he served the food to a seated resident. (Staff assisting in the dining room were also observed pouring hot water and coffee from the same carafes). He then returned to the steam table to repeat the process. Each time he served a piece of fish, he used the spatula with his right hand, and reached into the steam pan with his left hand to support the piece of fish onto the plate. He repeated this process multiple times, touching plates, trays, tray cards, glasses, cups, and containers of liquids, in addition to pieces of fish and bread with his same gloved hands.
At 12:15 p.m. cook-A retrieved a plate of salad and desert from the tray located beside the steam table for an employee, then removed his gloves, washed his hands, and reapplied gloves. He went to the table containing the tray cards, picked up a card, reviewed, picked up a small round bowl containing ground meat, placed it in the microwave, turned the dial to start, waited 20 seconds, removed the bowl and dumped the ground meat onto a plate, using his gloved hand, spread the meat into a flattened shape, when asked about temperature of the meat, cook-A retrieved a thermometer, used his left gloved hand to push the meat into a pile to check the temperature, which was 138 F. He then used his left gloved hand to push the meat back into the bowl and put back into the microwave to reheat. When he took it from the microwave, it had spilled out over the sides of the bowl. Cook-A rechecked the temperature and it was at 160 F. He then dumped it back onto the plate, dished the potatoes and vegetable onto the plate and took to the dining room where he placed it in front of a resident. He returned to the serving area, changed his gloves which were soiled with the ground meat. He picked up a glass from the dish rack of glasses with his gloved right hand, observed a gel like substance on the glass,

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21015	Continued From page 15 placed it onto the tray of soiled items, picked up a second glass which was also soiled, disposed of that glass, and retrieved a third from the same rack, which he filled with orange juice and placed on a tray. Without changing his gloves, cook-A retrieved a card and indicated it listed choice of deli meat. He stated he was not certain what this meant and would need to check with ADM. Cook-A carried the card, walked across the hall to the keypad kitchen door, keyed in the code, opened the door and walked into the kitchen. The ADM was not present, so he returned, opened the kitchen door, same gloved hands, returned to the steam table, dished another plate with fish, potatoes, vegetable, and bread, same process touching items with same gloved hands. Served the plate to a resident in the dining room. He then stated he would ask the resident what he meant by Deli meat. Cook-A went over to the resident seated in a wheelchair, placed his right gloved hand on the handle of the wheelchair and resident's back and asked him about his meat choice. With no glove change of hand hygiene, cook-A, again crossed the hall to the kitchen, opened the door via the keypad, entered the kitchen, crossed to the walk-in cooler, which he opened with his gloved hands, entered, and returned with a plastic bag containing slices of precooked, deli style ham. He placed the package of ham on the table in the kitchen, looked around, then picked up the package containing the ham, same gloved hands, opened the kitchen door and exited returning to the steam table where he placed the bag of ham on the front counter of the steam table, opened the package, reached into the package with his left gloved hand and took out several slices of ham which he held in his left gloved hand, picked up a pair of scissors from the cart beside the steam table and cut the ham into pieces, placing them onto a	21015		

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plate. When finished cutting up the meat, he returned the scissors to the cart, placed the package of meat on the cart containing salads for staff meals. Cook-A added potatoes to the plate, filled a glass with juice and a coffee and served the meal to the resident. He then returned to the steam table and continued dishing meals. 12:25 p.m. cook-A continued the same process, but now using his same gloved hands to pick up the fish from the steam table and place onto plates, then dish other foods with scoop, and use hand to place a slice of break on top of the plate. Cook-A took a second bowl of meat and a bowl containing potatoes, heated in the microwave, and checked temperature which was at 130 F. He returned the bowls to the microwave and reheated this time with temperature of 165 F. Used his gloved hands to arrange ground meat on plate, dumped potatoes onto plate, and served to resident in dining room. Cook-A picked up a slice of bread with same gloved hand, retrieved the scissors from the cart and cut off the bread crust before placing the slice of bread on top of the plate of food, which was then served.
12:50 p.m. cook-A reported everyone had been served. When interviewed he reported he had never been told he needed to check the temperature of pureed or mechanical foods, but just heated and served. When asked how he knew how much food was contained in the bowl of mechanically altered foods, he replied it was the same as what was served on the seam table, but he didn't measure it. The small bowls of food were on the table beside the steam table until they were heated and served. When asked about hand hygiene and glove changes, repeated he should have changed his gloves more frequently, and did not reply when asked about touching food with his gloved hands.
Interview at 12:55 p.m. with Cook-A reported he

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had never been oriented to the kitchen when he started but had worked for a local food service company that had very strict protocols for food safety, so he was comfortable with his job duties.

Interview on 3/29/24 at 2:30 p.m. with the DM identified her expectation that dietary staff followed infection control practices with glove changing between tasks, and if they touched a food item. She reported cook-A was employed when she took over in the kitchen and she had not reviewed his training or assessed his competency with food service tasks.

Interview on 3/29/24 at 3:50 p.m. with the registered dietitian (RD) identified her expectation for all staff to be trained and follow food safety and hand hygiene guidelines. She reported it was not acceptable to touch food and potentially contaminated services without performing appropriate hand hygiene and glove changes before returning to serving food.

Review of the December 9, 2021, policy preventing foodborne illness-food handling identified all employees who handle, prepare, or serve food were to be trained in practices of safe food handling, and prevention of foodborne illness. Employees were to demonstrate both knowledge/competency in practices prior to working with food or serving food to residents.

SUGGESTED METHOD OF CORRECTION:
The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs.

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21015	Continued From page 18 The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and	21390		4/24/24

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21390	Continued From page 19 incontinence products; and l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection control practices in accordance with Centers for Disease Control (CDC) recommendations to prevent and/or mitigate the risk of the spread of communicable disease Influenza such as utilization of appropriate personal protective equipment (PPE), appropriate hand hygiene, preventing ill staff from working, implement active symptom screening for residents and staff, and providing staff ongoing education during outbreak. The facility's failures resulted in an Influenza A outbreak that effected 9 out out of 23 residents and had the potential to effect the remaining residents, visitors, and staff. Findings include: During entrance conference on 3/27/24, State Agency was made aware of an Influenza A outbreak in the facility. The outbreak started that began on 3/16/24, effected 9 out of 23 residents. Five residents were on isolation precautions at the start of the survey. and is continuing and affecting nine out of 23 residents. Five residents (R7, R11, R13, R14 and R15). Review of the facility's resident influenza A and isolation line listing, identified the following: R3 tested positive on 3/16/24, and ended isolation on 3/23/24, R6 tested positive on 3/17/24, and ended isolation on 3/24/24,	21390	Corrected	

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R16 tested positive on 3/18/24, and ended isolation on 3/25/24,
R9 started isolation on 3/18/24, and ended isolation on 3/25/24,
R12 started isolation on 3/19/24, symptomatic but tested negative,
R4 started isolation on 3/19/24, symptomatic but tested negative,
R15 tested positive 3/20/24, and ended isolation on 3/27/24,
R14 tested positive on 3/21/24, and ended isolation on 3/28/24,
R11 tested positive on 3/21/24, and ended isolation on 3/28/24,
R7 tested positive on 3/22/24, and ended isolation on 3/29/24,
R13 tested positive on 3/22/24 and ended isolation on 3/29/24.

In review of the facility's IC surviellance program activities, it was not evident employee illness line listing was completed, no record of employee or resident active screening, and not evident audits and education were completed after Influenza outbreak.

During an interview on 3/28/24 at 10:19 a.m., assistant director of nursing (ADON) who identified herself as the infection preventionist (IP) and responsible for the facility's infection control (IC) surveillance program. IP reviewed active surveillance line listing and IC program activities. IP stated line listing for residents identified nine residents; R3 who resided on the east hallway was the first positive case on 3/16/24. Then on 3/17/24, the virus spread to the west hallway and four more residents R6 and R16 tested positive/R4 and R12 were symptomatic but tested negative. On 3/20/24, three more residents (R15, R14, R11) tested

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21390	Continued From page 21 positive. R7 who resideded on the west hallway tested positive on 3/22/24 and R13 who resided on the east hallway tested positive on 3/22/24. IP indicated consistent staffing was attempted however was not followed by NAs. IP reported active symptom screening for residents was never implemented because she had not been aware of the CDC guidance and recommendation. IP reviewed the illness tracking for staff, she confirmed tracking for staff was not completed and had not been completed in real time. IP explained staff would not communicate illnesses with her and the department managers would not communicate ill calls. IP would update the form when she became aware, sometimes days later. IP stated the facility had not implemented active screening for staff, she was unaware of that recommendation by the CDC as a prevention strategy. IP referenced the staff line listing on 3/18/24, which identified the dietary manager (DM)-A came in sick to work. IP had told her to go home because she did not look well however, DM-A did not go home, continued to work in the kitchen with residents food, refused to get tested, and shortly there after mulitple dietary staff became ill with the flu. IP explained audits that would identify causal factors of spread and to identify staff education to prevent or mitigate the risk of further spread of the virus were not completed because she was not afforded enough time. IP stated she had continously spent a lot of time out on the floor providing in the moment education to direct care staff because she had identified staff were not washing their hands nor using PPE appropriately. IP voiced frustration because despite ongoing constant reminders and eduation staff continued to not practice apporopriate use of PPE or hand hygiene. IP explained she thought the influenza spread was related to several factors including staff not	21390		

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performing appropriate hand hygiene, wearing appropriate PPE and staff coming in sick to work. Furthermore, IP did not know that she had to report this influenza outbreak to the state agency (SA).

Review of the facility's employee line listing for March 2024, identified the following:
-DM-A had symptoms of sore throat, nasal congestions, diarrhea, and cough: Symptom start date 3/2/24, illness reported on 3/3/24, DM-A's lat shift worked prior to symptom onset was 3/1/24. DM-A returned to work on 3/5/24.
-Nursing assistant (NA)-C had symptoms of fever that started on 3/17/24. NA-C reported symptoms on 3/18/24, NA-C's last shift worked prior to symptoms was 3/16/24, and returned to work on 3/21/24,
-Licensed practical nurse (LPN)-A symptoms of cough and nasal congestion started on 3/17/24. LPN-A reported symptoms on 3/17/24 and worked on 3/17/24. LPN-A returned to work on 3/20/24. LPN-A was treated with Tamiflu (antiviral used to treat influenza),
-DM-A had resumption of symptoms with headache and nasal congestion that started on 3/18/24. DM-A reported symptoms on 3/18/24 and worked. DM-A's last worked shift prior to symptom onset was 3/16/24. DM-A returned to work on 3/20/24,
-NA-C symptoms of headache and fever, started on 3/18/24, reported on 3/18/24, last shift worked 3/16/24, and returned to work on 3/22/24,
-DA-D symptoms of cough, headache, sore throat, and nasal congestion, started on 3/20/24, reported on 3/20/24, last shift worked 3/19/24, and returned to work on 3/22/24,
-NA-E symptoms of chills and headache, started on 3/20/24, reported on 3/20/24, last shift worked 3/19/24, and returned to work on no date listed,

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21390	Continued From page 23 -C-B symptoms of cough, fever, headache, nasal congestion, started on 3/21/24, reported 3/21/24, last shift worked 3/21/24, and returned to work on 3/27/24 -ADON symptoms of chills, cough, fever, body aches, started on 3/22/24. Reported on 3/22/24, last shift worked 3/21/24 and returned to work on 3/27/24, -AA symptoms of runny nose and nasal congestions, started on 3/26/24, reported 3/26/24, last shift worked 3/26/24 and returned to work on 3/27/24, symptoms lasted less than 24 hours. All above employees tested negative for COVID 19. During an observation on 3/27/24 at 1:21 p.m., trained medical aide (TMA)-B was observed in R13's room who was droplet contact precautions without PPE on. There was a sign posted on the door that directed the use of gloves, gown for contact precautions and gown, gloves and face mask for droplet precautions. TMA-B was not wearing any PPE when observed walking away from R13 to exit the room. TMA-B confirmed R13 had influenza A and TMA-B should have been wearing a mask at least. During a tour of facility on 3/27/24 at 4:30 p.m. observed five residents (R7, R11, R13, R14 and R15) had Contact and Droplet isolation signs on the doors of their room; all of the room doors were open. At 4:35 p.m., nursing assistant (NA)-J and NA-F were observed going in and out of resident's room, including those on isolation, providing cares to different resident's without changing their facial masks, R2-(on isolation or already had?), R11, R14 and R16 (on isolation or already had?).	21390		

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Observation of the DM on 3/27/24 and 3/28/24 at various times was of her coughing and sneezing while working both in and out of the dietary department. She was observed wearing a mask, which was covering her mouth, but not her nose. When questioned regarding persons working when ill, DM reported she had stayed home when she was ill the previous week but did not have a fever and needed to cover shifts. DM reported she had been asked to be tested for Influenza-A but declined and reported that was what residents and other staff had, so she didn't feel she needed to spend the money to be tested.

During an observation on 3/28/24, at 10:15 a.m. all five residents who were on contact precautions had their doors open.

During an observation on 3/28/24 at 10:17 a.m., R14's room had a sign on the door that directed the use of droplet precautions. R14 laid in bed resting peacefully without evidence of agitation or restlessness. NA-A was observed going into R14's without any PPE on. NA-A walked over to R14 leaned down to talk into R14's ear, inches away from his face and touched R14's bed. NA-A then walked out of R14's room without performing hand hygiene. When questioned about hand hygiene and PPE usage, NA-A raised her hands in the air and confirmed R14 required droplet precautions and staed, "No I did not put on a gown or mask". NA-A quickly turned and walked down the hallway into another resident's room who was on hospice, had not had Influenza A, and did not have symptoms of illness. NA-A had not performed hand hygiene prior to entering this residents room. When NA-A walked out of the room she again did not perform hand hygiene.

Review of facility policy Influenza, Prevention and

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Control of Seasonal, indicated:
-section symptomatic residents and visitors, 6b: providing instructions before visitors enter residents' room, on hand hygiene, limiting surfaces touched and use of PPE while in resident's room.
-Under section symptomatic healthcare workers, 2. Staff who develop fever and respiratory symptoms are: a. instructed not to report to work, or if at work, to stop resident-care activities, don a facemask, and promptly notify their supervisor and the IP and/or designee before leaving work; b. excluded from work until at least 24 hours after they no longer have a fever (without the use of fever reducing medicines). Those with ongoing symptoms will be considered for evaluation by the IP and/or designee to determine appropriateness of contact with residents.
-under infection precautions, 1. Contact and droplet precautions are implemented for residents with suspected or confirmed influenza for seven days after the illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.

SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.

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21390	Continued From page 26 Time Period for Correction: Twenty-one (21) days.	21390		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide adequate and specialized rehabilitative services of occupational therapy (OT) and physical therapy (PT) therapy according to residents individualized needs based on a comprehensive assessment for 2 of 2 residents (R2 and R10) who had orders for physical therapy (PT) and occupational therapy (OT). Findings include: R2's diagnoses included bilateral osteoarthritis, sepsis, pressure wound on buttocks and weakness. R2's admission Minimum Data Set (MDS) dated 3/11/24, indicated R2 was admitted to the facility on 3/5/24, did not have cognitive impairment, did have impairment to range of motions (ROM) to one upper extremity and both lower extremities, used a walker and wheelchair. R2 was dependent with lower body dressing and putting on/off footwear, personal hygiene and sit to lying	21510	Corrected	4/24/24

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position. R2 required maximal assist with toilet hygiene, shower/bathing, rolling side to side in bed, sit to stand position, and transfers. Partial assist with upper body dressing, ambulating 10 feet and wheeling wheelchair 50 feet with two turns. R2 was receiving OT with a start date of 3/7/24, and PT with a start date of 3/11/24.

R2's admission physician orders dated 3/5/24, included OT and PT both to eval and treat.

R2's Activities of Daily Living (ADL) care plan dated 3/6/24, R1 is extensive assist of one staff for bathing/showering, dressing and toilet use. R2 requires set up for personal and oral hygiene. Independent with bed mobility, with the use of bedrails and trapeze. R2 independent in room per therapy and extensive assist of one staff, front wheeled walker, gait belt and appropriate footwear for ambulation out of room.

R2's OT evaluation and plan of treatment dated 3/7/24, ordered a frequency of three to five times per week for eight weeks to improve resident's rehab potential, maximize resident's rehab potential, increase independence with activities of daily living (ADLs), maximize independence with ADL's, and facilitate independence with ADLS inorder to enhance resident's quality of life by improving ability to return to prior living situation, certification period of 3/7/24 to 4/5/24.

Review of R2's OT notes indicated R2's evaluation was completed on 3/7/24. According to the record R2 was provided services on 3/8/24, 3/11/24, 3/15/24, 3/18/24, 3/20/24, 3/22/24, and 3/25/24. Did not consistently meet the three to five times per week per the ordered treatment plan.

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R2's PT evaluation indicated R2 was referred to therapy status post hospitalization due to functional decline at home. The plan of treatment dated 3/11/24, directed a frequency of 8 times per period of 4 weeks, intensity of daily with certification period of 3/11/24 to 4/9/24. R2's short term goals included:
- Patient will safely perform bed mobility tasks with minimum assist without use of siderails in order to prepare for gait activities (Target 3/24/24). Prior level of function was independent; baseline on 3/11/24 was moderate or modified assist.
-Patient will safely perform functional transfers with contact guard assist in order to return to prior level of functional abilities. Prior level of function was independent; baseline on 3/11/24 was minimal assist.
-Patient will safely ambulate on level surface 250 feet using FWW with stand by assist with normalized gait patter 100% of the time to increase independence in the facility. Prior level of function was independent; baseline on 3/11/24 was contact guard assist.

Review of R2's PT notes identified from 3/11/24 to 3/29/24, R2 received therapy on 3/11/24 and on 3/29/24.
-R2's Treatment Encounter Note dated 3/11/24, indicated the session was completed by the physical therapist (PT)-B. The note included Gait training: gait training to normalize patter, PT provided minimal assist during ambulation for patient safety. Patient ambulated 1 x 250 feet, 1 x 100 feet with FWW. Will progress as able. The note did not identify session duration time.

-R2's Treatment Encounter Note dated 3/29/24, indicated the session was completed by PT-C. The note included Gait training to improve

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functional mobility and return patient to previous level of function. Patient ambulated 250 feet with ww (sic) stand by assist with cues for postural alignment and energy conservation techniques. Seated lower extremity exercises in all joints/planes with "YTB" in order to improve stability during functional ability, forward and backward ambulation to promote ankle strategies and self righting ability. Cues for pacing when ambulating backwards with contact guard assist.

All physical therapy notes and evaluations were requested. The requested documentation received from 3/11/24 through 3/29/24 did not include an evaluation of goal status and/or effectiveness of only having physical therapy for two therapy sessions in 18 days.

R10's diagnoses included stroke with weakness to one side of his body.

R10's admission MDS dated 3/7/24, indicated an intact cognition, with ROM impairment on one side of his body, used a wheelchair and walker. R10 was dependent with toilet hygiene, lower body dressing, putting on/off footwear. R10 required substantial assist with upper body dressing, personal hygiene, sitting to lying position, all transfers, and walking 10 feet. R10 required moderate assist with oral hygiene, turning side to side in bed, and lying to sitting position. R10 was independent with wheeling 50 feet with two turns and wheeling 150 feet once in wheelchair. R10 received OT with a start date of 3/3/24 and PT with a start date of 3/5/24.

R10's admission physician orders dated 3/1/24, cardiac discharge instructions indicated that R10 should have as much activity as possible, but pulse should remain below 110 for 1 month

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21510	Continued From page 30 following his procedure on 2/28/24. Please ambulate R10 to meals with front wheeled walker (FWW)/gait belt, assist of two staff, while monitoring his pulse and oxygen levels, followed by a wheelchair. PT to evaluate and treat. OT to evaluate and treat. R10's PT evaluation indicated R10 required physical therapy related to status post hospitalization due to cervical cord compression, cervical decompression surgery, angiogram procedure, and functional decline. The plan of treatment dated 3/5/24, indicated frequency of one to five per week for duration of four weeks, intensity was identified as daily with certification period of 3/5/24 to 4/3/24. PT goals were as follows: -Patient will safely perform functional transfers with contact guard assist in order to facilitate increased participation with functional daily activities (Target date 3/18/24) Previous level of performance was independent; baseline on 3/5/24 was minimal assist. -Patient will safely ambulate on level surfaces 200 feet using FWW with Min assist 100% of the time while maintaining good balance to allow patient to get to bathroom with decreased assistance (Target date 3/18/24) Previous level of performance was unlimited distance independently; baseline on 3/5/24 was 200 feet with moderate assist. -Patient will increase dynamic standing balance to fair- and using righting reactions 100% of the time to right self in order to reduce the risk for falls (Target 3/18/24). Previous level of function was normal; baseline on 3/5/24 was poor+ moderate assist and upper extremity support to stand and reach ipslaterally without LOB; unable to weight shift. -Patient will safely perform functional transfers	21510		

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	00731	A. BUILDING: ______ B. WING ______	C 03/29/2024

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) COMPLETE DATE
21510	Continued From page 31	21510		

with independely in order to facilitate increased participation with functional daily activities (Target 4/3/24). Previous level of function was independent; Baseline was on 3/5/24 was minimal assist.
-Patient will safely ambulate on level surfaces 200 feet using FWW with modified independence 100% of the time while maintaining good balance to allow patient to get to bathroom with decreased assistance (target date 4/3/2024).

R10's progress notes identified between 3/5/24 and 3/28/24, R10 completed only three physical therapy session on 3/7/24, 3/11/24, and 3/28/24.
-PT Encounter Note dated 3/7/24, indicated physical therapy assist (PTA) completed the session. The note included R10 ambulated 200 feet with contact guard assist, was fatigued after 15 feet, and became unsteady. Patient does ambulate with ataxic gait pattern at times. Patient performs bed mobility with modified independence supine to sit. The note did not identify time duration of the visit.
-PT Encounter Note dated 3/11/24, indicated physical therapist (PT)-A completed the session. The noted included Patient implemented gait training to progress functional ambulation ability and independence. Patient required contact guard assist during ambulation for safety. R10 ambulated 2 x 400 feet with FWW. Will progress as able. The note did not identify time duration of the visit.
-PT Encounter note dated 3/28/24, indicated PT-B completed the session. The note included PT provided stand by assist during ambulation for safety. Gait training; gait training to normalize gait pattern, directional changes, training strategies to safely maneuver around obstacles and self correction during task performance. Patient ambulated 4 x 200 feet with 4WW. Continued

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	00731	A. BUILDING: ______ B. WING ______	C 03/29/2024

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21510	Continued From page 32	21510		

skill PT services necessary to progress to modified independence with 4WW. The note did not identify time duration of the visit.
All physical therapy notes and evaluations were requested. The requested documentation received from 3/5/23 through 3/28/24 did not include an evaluation of goal status and/or effectiveness of only having physical therapy once per week or the 3 (three) therapy sessions.

During an interview on 3/28/24 at 12:14 p.m., physical therapist (PT)-A, stated he was on a as needed basis (PRN) and attempted to get to the facility once a week. PT-A stated that he did not know who was providing the PT sessions when he was not in the building. There was only one intermittent therapy assistant and was not aware of what the PTA's schedule was. PT-A stated the lack of having a full time PTA was hurting the residents because although there may not be an overall decline the patients were not progressing like when the therapy department had more help. Further though there had been some residents that had been discharged from therapy that he feels should not have been. PT-A could not think of specific examples. PT-A indicated the facility had been doing "teletherapy" and did not like doing things that way, he preferred to see the patients in person. PT-A indicated he did not think the facility had been admitting resident who required skilled care because there was not an adequate number of staff to provide the necessary services.

During an interview on 3/28/24 at 4:35 p.m., director of therapies (DOR)-A, stated that he was a Certified Occupational Therapy Assistant (COTA). DOR-A stated he was at the facility 3-5 times per week to provide occupational therapy services. DOR-A explained the facility switched

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	00731	A. BUILDING: ____ B. WING ____	C 03/29/2024

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21510	Continued From page 33	21510		

Continued From page 33

therapy companies on 2/1/24. The PT-A only comes in about once a week with no set day. DOR-A would inform PT-A when new residents were admitted to the facility. DOR-A confirmed that the facility did not employee a full time PTA and PTA had not been at the facility for about 3 weeks. DOR-A further indicated that the facility was actively working on hiring physical therapist and physical therapy aides to meet the residents' needs.

Request for policies for therapy was requested but not received.

Facility Assessment last reviewed by the quality assurance committee identified the facility provided PT/OT services. Part 3: Facility Resources needed to provide competent support and care for our resident population every day and during emergencies included: "Therapy Services (e.g., OT, OTA, PT, PTA...)"

SUGGESTED METHOD OF CORRECTION: The administrator, DON, with assistance from contracted therapy services or designee could review and revise policies and procedures to ensure residents requiring specialized rehabilitative services (ST, OT, PT) are provide the required services or obtain those services from an outside source. The administrator, DON, or designee should audit all resident medical records and physician orders and newly admitted resident records to ensure all residents who require services are receiving appropriate therapy according to physician orders and/or assessments, in order to enhance or maintain resident abilities. Those audits should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00731	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 03/29/2024

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21510	Continued From page 34 performed in a measurable way, (ex: weekly x 4 weeks, then monthly x ... etc.) The administrator, DON, or designee should take the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance and the need for further monitoring. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21510		