STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165507	A. BUILDING _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW VILLAGE	2571 GUTHRIE AVENUE DES MOINES, IA 50317

(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 Correction Date 11/21/21 The following deficiencies result from the facility's annual health survey and investigation of facility-reported incidents 98833-I and 100284-I. Both facility reported incidents were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide a call light within reach to assist with their needs for 1 of 17 residents. (Resident #64) The facility reported a census of 67. 1. The Minimum Data Set (MDS) assessment with a reference date of 9/30/21 for Resident #64 identified a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicated severe cognitive impairment. According to the MDS, the resident required the assistance of one staff for transfers, personal hygiene, and bed mobility. Diagnosis included muscle weakness and	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Prager — TITLE: Executive Director — (X6) DATE: 11/10/21

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 558	Continued From page 1 Alzheimer's disease. The Care Plan 12/5/19 dated revealed keep call light in reach at all times. On 10/11/21 at 1:38 pm Resident #64 sitting in wheelchair in his room and the call light was placed over the night stand behind his wheelchair out of reach. On 10/11/21 at 1:44 pm Staff A, Licensed Practical Nurse, stated that every resident should have their call light within reach. Staff A entered the resident's room and gave him his call light. On 10/13/21 at 10:34 am the Associate Director of Nursing stated she would expect all residents to have their call light in reach. A Call Light facility policy dated 12/31/18 directed staff to place the call light so it is accessible to the resident at all times when the resident is in their room and to secure the call light to stay within access of the resident.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		

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F 657	Continued From page 2 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and staff interviews, the facility failed to revise the Care Plan to reflect the actual care needs and current condition of the resident for 1 of 17 sampled residents (Resident #18). The facility reported a census of 67 residents. Findings include; According to the Minimum Data Set (MDS) assessment tool dated 7/16/21, Resident #8 had diagnoses that included respiratory failure and dependent on supplemental oxygen. The MDS documented the resident scored 15 out of 15 possible points on the Brief Interview for Mental Status (BIMS) test. A score of 15 indicated the resident showed no impairment with their cognitive abilities. The MDS also documented Resident #18 required limited assist of staff for bed mobility and surface-to-surface transfers and had utilized oxygen therapy during the last 14 days of the assessment.	F 657		

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F 657	Continued From page 3 Observation on 10/12/21 at 9:16 am revealed Res #18 received oxygen (O2) at 4 Liters (L) per nasal cannula. The Care Plan dated 4/12/21 documented the resident chose moderate activity involvement and required 5 L of O2 at all times. A Physician Order Report dated 9/13/21-10/31/21 directed staff to administer Resident #18 3 L of O2 continuously and titrate for comfort initiated 5/4/21. A Medication Administration Record (MAR) dated 9/1/21-9/30/21 documented the resident received 3 liters of oxygen continuously and titrated for comfort. On 10/31/2 at 10:33 am, the Associate Director of Nursing stated she would expect the Care Plan to match the physician's order related to the oxygen therapy.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide adequate	F 689		

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F 689	Continued From page 4 nursing supervision to reduce hazards to residents for 1 of 2 residents reviewed when a staff person did not use a gait belt when providing assistance to Resident #13 during a surface-to-surface transfer in accordance with the resident's individualized plan of care. The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) dated 07/13/21 identified the resident scored 8 of 15 possible points on the Brief Interview of Mental Status (BIMS) test, which indicated the resident experienced moderate cognitive impairment. The MDS revealed the resident did not walk in their room or the corridor and required extensive physical assist of 2 plus persons for toilet use and bed mobility. The MDS documented the resident required extensive assist of 1 staff for personal hygiene, dressing, and locomotion in the wheel chair, was not steady, and could only stabilize with staff assistance when moving from a seated to a standing position, moving on and off toilet, and for surface to surface transfers (transfers between chair and wheelchair) The MDS recorded Resident #13 had active diagnoses that included: anemia, coronary artery disease, hypotension, arthritis, spinal stenosis in the lumbar region without neurogenic claudication, lower back pain, facioscapulohumeral muscular dystrophy, tremors, adult failure to thrive, weakness, abnormalities of gait and mobility, and unsteadiness on feet. The MDS documented the resident received antidepressants 7 out of 7 days and opioids 4 out of 7 days of the assessment reference period.	F 689		

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F 689	Continued From page 5 The Care Plan updated 10/12/21 identified the resident was a rehabilitation potential for activities of daily living (ADL) that included transfers and mobility and directed staff to provide one assist to ambulate (walk) or transfer with the gait belt and front wheel walker. The Physical Therapy Progress and Discharge Summary dated 07/13/21 and signed by Staff D revealed resident had demonstrated poor progress toward established physical therapy goals and would continue to recommend assist x 1 staff for functional transfers and a wheel chair for mobility. Observation on 10/12/21 at 09:17 AM revealed Staff E, CNA entered Resident #13's room to assist him to transfer from his wheel chair to his lounge chair. The resident ambulated while the CNA held the back of his pants. Staff E raised Resident #13's feet in the lounge chair. Staff E did not use a gait belt during the transfer. On 10/12/21 at 03:07 PM, the resident reported staff did not transfer him with a gait belt again today and commented it totally depended on which staff were working. He added the new staff use the gait belts and staff that have been here longer tend to not use the gait belts. Observation on 10/13/21 at 09:34 AM revealed Staff F and Staff G applied a gait belt around the resident's waist and both physically assisted him from the wheel chair to the lounge chair. On 10/13/21 at 09:43 AM, Staff F stated Resident #13 typically requires 1 staff assist with gait belt to transfer, but some days he is weaker. She stated care plans are not updated very often and	F 689		

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F 689	Continued From page 6 you got to know the residents, especially being an agency nurse. In an interview on 10/13/21 at 02:05 PM., Assistant Director of Nursing (ADON) affirmed that staff are expected to use a gait belt for all resident transfers unless the resident is in the process of ambulating and placing a gait belt around their waist at that time would be a safety hazard. The facility policy titled Transfer/ambulation Assist Using Gait/transfer belt revised on 08/26/19, instructed the staff to use gait belts for all residents who require physical support for mobility or safety in transfers and specified the resident will be assessed for appropriate transfer status by physical therapy, occupational therapy, or a nurse.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		

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F 755	Continued From page 7 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and facility policy review, the facility failed to document narcotic counts to ensure accurate reconciliation for all controlled medications for 4 of 4 units reviewed. The facility reported a census of 67 residents. Findings include: During the medication administration task on 10/18/21 at 9:00 AM, review of narcotic count sign-off sheets for 3 of 4 units revealed the sign-off sheets as incomplete and 1 unit had no narcotic count sign-off sheet. The Leblanc unit narcotic sign off sheet missed 18 nurse initials of 70 opportunities for medication reconciliation from 10/1 - 10/18/21. The Magnolia unit narcotic sign off sheet missed 30 nurse initials of 70 opportunities for medication reconciliation from 10/1 - 10/18/21. The Tulip unit narcotic sign off sheet missed 18 nurse initials of 70 opportunities from 10/1 - 10/18/21. The Lilac unit had no	F 755		

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F 755	Continued From page 8 narcotic sign off sheet for the month of October, 2021. On 10/18/21 at 9:30 AM, Staff N, LPN (Licensed Practical Nurse) stated the night nurse and medication aid signed off before she started her shift and she did not do another narcotic check when starting her shift. Staff N stated she did not do her due diligence as she was supposed to sign off with the night nurse this morning. On 10/18/21 at 10:05 AM the ADON (Assistant Director of Nursing) stated that her expectation that two nurses check narcotic counts at the beginning and end of each shift. She stated she planned to start education on this right away. The facility's Narcotic Count policy, revised 7/18/19, instructed that Schedule II-V medications are counted at the end of each shift. The count is done by having one nurse look at the index and corresponding sign-out page. A second nurse or TMA/CMA (medication aides) confirmed the quantity remaining in the corresponding medication card, box or bottle. Both staff sign the count notebook to indicate the count was correct.	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 and local laws or regulations.	F 812		

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F 812	Continued From page 9 (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 clinical record review, observation, staff interview and facility policy review, facility staff failed to assist a resident to eat without touching their food with bare hands for one of three residents observed (Resident #26). The facility reported a census of 67. Findings include: The Minimum Data Set (MDS) assessment dated 8/11/21 for Resident #26 documented a Brief Interview for Mental Status (BIMS) score of 1, indicating severe cognitive and memory impairment. Resident #26 required extensive assist of one staff member to eat. The resident's Care Plan revised on 8/27/21 documented Resident #26 required regular texture finger foods without restrictions. Observation on 10/12/21 at 8:45 AM revealed Staff A, LPN (Licensed Practical Nurse) assisted Resident #26 to eat his breakfast. Staff A stood next the resident and used her ungloved thumb to hold down the waffle so she could cut it with a fork. Staff A then fed the resident. Observation revealed Staff A touched the resident's food twice	F 812		

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F 812	Continued From page 10 without washing her hands or putting gloves on. In an interview on 10/14/21 at 12:50 PM, the Assistant Director of Nursing stated the expectation is that staff do not touch residents' food. If staff have to touch a resident's food, they should wear gloves but it is preferred they use silverware. The facility's policy on Hand Hygiene dated 10/2/18 instructed that handwashing is necessary before and after eating or handling food.	F 812		
F 880 SS=E	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;	F 880		

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F 880	Continued From page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism 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.	F 880		

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F 880	Continued From page 12 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observations, staff interviews and facility policy review, facility staff failed to follow the Center for Disease Control (CDC) guidelines for personal protective equipment in a medical facility by not wearing eye protection while performing resident cares when community transmission is considered at high risk for five residents (#13, #19, #64, #219 and #228). Staff also failed to follow infection prevention and control procedures and standard precautions during medication administration for 2 of 7 residents observed (Residents #13 and #228). The facility reported a census of 67 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/13/21 identified Resident #13 had a Brief Interview of Mental Status(BIMS) score of 8 which indicated moderate cognitive impairment. The assessment recorded Resident #13's active diagnoses included anemia, coronary artery disease, hypotension, arthritis, spinal stenosis in lumbar region without neurogenic claudication, lower back pain, facioscapulohumeral muscular dystrophy, tremors, adult failure to thrive, weakness, abnormalities of gait and mobility, and unsteadiness on feet. The signed Physician Order Report dated 9/10/21 instructed staff to administer Mucinex (to loosen mucous) tablet 600 milligrams (mg), twice a day, and omeprazole (an antacid) 20 mg, once per day.	F 880		

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F 880	Continued From page 13 Observation on 10/12/21 at 9:17 AM revealed Staff H, Registered Nurse (RN) assessed the resident's vital signs and administered his medications. During the observation, Staff H picked up one pill from a cup with her ungloved hands and placed it in the resident's mouth. 2. The MDS assessment dated 9/23/21 recorded Resident #228's active diagnoses included osteoporosis, arthritis, anxiety disorder, chronic obstructive pulmonary disease, respiratory failure, dementia without behavioral disturbances, oxygen dependence, emphysema, and dysphagia. a. The signed Physician Order Report signed 9/10/21 instructed to administer acetaminophen (for pain) 325 mg, 2 tablets, three times a day; donepezil (for dementia) 10 mg once a day and setraline (antidepressant) 50 mg two tabs once a day. On 10/13/21 at 8:46 AM Staff H gave Resident # 228 her medications at the breakfast table. While dispensing pills from a medication cup in to resident's mouth, 2 pills fell into Staff H's ungloved hand. Staff H picked up pills with her bare hands and then placed the pills in the resident's mouth. Staff H did not wear gloves and did not wash hands after the administration. Interview with Assistant Director of Nursing (ADON) on 10/13/21 at 2:05 PM revealed her expectation would be staff would wear gloves to touch anything placed in a resident's mouth. The facility's policy titled Infection Prevention and Control Program, revised 10/9/20, revealed that standard precautions will be used by all staff to	F 880		

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	165507	A. BUILDING _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 14 prevent healthcare worker to resident transmission of infectious organisms. b. Resident #13's Care Plan updated 10/12/21 identified the resident had rehabilitation potential for activities of daily living (ADL) potential including transfers and mobility. The Care Plan directed staff to provide the assistance of one with walking or transfer, use a gait belt and front wheel walker. The care plan also directs staff to ensure resident will maintain ability to feed self. During the observation of medication administration on 10/12/21 at 9:17 AM, Staff E, Certified Nursing Assistant (CNA) wheeled Resident #13 into his room from the bathroom prior to the medication pass. Staff H assessed his vital signs and administered the medications. Neither Staff E or Staff H wore eye protection during these cares. On 10/11/21 at 4:11 PM, the ADON stated after talking to Administrator, the Centers for Medicare/Medicaid Services (CMS) or CDC do not mention that staff at nursing homes need to wear eye protection if county positivity rate is considered high. The Iowa Department of Public Health directed that eyewear be worn if in an outbreak. The facility had no COVID-19 infections at this time as residents are 100% vaccinated and staff is 70% vaccinated. The ADON stated that no staff currently wore eye protection for cares unless it is their preference. On 10/13/21 at 12:15 PM, the Corporate Clinical Practice Coordinator stated regarding use of eye protection, corporate owned 4 facilities and the only one requiring eye protection when not in outbreak status is in Minnesota. The facility	F 880		

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F 880	Continued From page 15 follows the Iowa Department of Public Health recommendations and CMS recommendations regarding personal protective equipment regulations. Iowa, North and South Dakota, and Florida along with CMS do not require eye protection unless in outbreak status. She stated she planned to look into the CDC guidelines from 9/10/21 and would discuss this with Administrator. On 10/13/21 at 12:37 PM, Staff K, CNA stated staff is not required to wear eye protection because they are not in outbreak status. The information came from the facility's administration. The facility policy titled COVID-19 Protocol-SNF (Skilled), revised 10/1/21, directed that employees will wear eye protection in resident care areas based on your state requirement for facilities that are not currently experiencing an outbreak. The Center for Disease Control and prevention (CDC) website (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html) titled "Implement Universal Use of Personal Protective Equipment (PPE) for HCP" states that if SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), health care provider (HCP) working in facilities located in counties with substantial or high transmission should also use PPE as described below: NIOSH-approved N95 or equivalent or higher-level respirators should be used for: a. All aerosol-generating procedures (refer to Which procedures are considered aerosol	F 880		

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F 880	Continued From page 16 generating procedures in healthcare settings?) b. All surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) c. Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP working in other situations where multiple risk factors for transmission are present. One example might be if the patient is unvaccinated, unable to use source control, and the area is poorly ventilated. d. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. Review of CDC's COVID-19 Data Tracker revealed that on 10/12/21, Polk County Iowa had a high COVID-19 community transmission rate. 3. The MDS assessment dated 9/30/21 recorded Resident #64's BIMS score as 3 out of 15, indicating severe memory and cognitive impairment. The MDS identified the resident required extensive assistance from staff for bed mobility, transfer, toilet use, and personal hygiene. The MDS listed diagnoses that included renal insufficiency and obstructive uropathy (blockage). The MDS revealed an indwelling catheter. On 10/13/21 at 10:59 am Staff B, Certified Medication Aide (CMA) entered Resident #64's room to empty the indwelling catheter. Staff B placed a barrier on the floor, applied alcohol to the port and drained the catheter into a graduate. Staff B did not wear eye protection while she	F 880		

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F 880	Continued From page 17 provided catheter care. 4. The MDS) assessment dated 9/29/21 documented Resident #222's BIMS score as 14 out of 15, indicating no cognitive or memory impairment. The MDS identified the resident required extensive assistance from staff related to bed mobility, transfer, and toilet use. The assessment listed active diagnoses that included peripheral vascular disease (narrowing of the arteries) and heart failure. The MDS also recorded Resident #222 admitted with 4 unstageable pressure ulcers. During observation on 10/13/21 at 10:39 am Staff C, Licensed Practical Nurse (LPN) and the ADON entered Resident #222's room and washed their hands. Staff placed wound supplies on a barrier on a tray table. The ADON removed the resident's dressing from a wound on his buttock then washed her hands. The ADON cleansed the wound as ordered with normal saline and then measured the wound. The ADON wore a mask and gloves during the wound care, but not wear eye protection while providing the wound treatment. Staff C then applied the new dressing as ordered and also did not wear eye protection during the wound care. 5. The Resident #219's MDS assessment of 9/1/21 documented a BIMS score of 14. The resident required the nutrition through a gastric tube. The care plan last revised on 9/17/21 revealed she has a gastric tube with enteral feedings and eats 3 meals a day. During observation 10/13/21 at 9:25 AM, Staff C	F 880		

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F 880	Continued From page 18 entered the resident's room, washed her hands and applied gloves. Staff C gathered equipment and fresh water to flush the gastric tube, checked placement by inserting air into the tube and listening with a stethoscope and then instilled 120 milliliters (ml) of water into the gastric tube. Staff C removed her gloves and washed her hands. Staff C did not wear eye protection during the care. 6. Resident #19's MDS assessment of 7/23/21 recorded a BIMS score of 7, indicating severe cognitive and memory impairment. Resident #19 required the assistance of 2 staff members for bed mobility, transfers, walking in his room and for toilet use. During observation on 10/13/21 at 9:20 AM, Staff I CNA returned Resident #19 to his room by wheelchair. Staff I sanitized her hands and put on gloves and assisted the resident to transfer to a recliner. Staff I did not wear eye protection during the care.	F 880		

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law.

F558-B
It is the policy of Valley View Village to place the call light so it is accessible to the resident at all times within the resident's room.

Regarding cited resident:
Regarding resident #64, staff were made aware of call light out of reach, nurse re-educated the CNA at the time and ensured the call light was placed within reach immediately.

Measures put in place to ensure deficient practice does not recur:
Reeducation was provided to staff regarding appropriate call light placement and following care plan.

Effective implementation of actions will be monitored by:
The Staff Education Nurse or Designee will audit call light placement 4 times per month for three months to ensure appropriate call light placement. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:
The Director of Nursing or designee is responsible for maintaining compliance.

Completion date for certification purposes only is: November 21, 2021

F657-D
It is the policy of Valley View Village to update resident care plans routinely to reflect resident's current condition and review for accuracy.

Regarding cited resident:
Regarding resident #18, the oxygen care plan was reviewed and updated to ensure accuracy of oxygen use.

Measures put in place to ensure deficient practice does not recur:
Care Plans of all residents receiving supplemental oxygen were reviewed and updated as needed.

Effective implementation of actions will be monitored by:
MDS Coordinator or designee will audit three care plans of residents receiving supplemental oxygen per month for three months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:
The Director of Nursing or designee is responsible for maintaining compliance.

Completion date for certification purposes only is: November 21, 2021

F689-D
It is the policy of Valley View Village to follow the transfer assist required per care plan.

Regarding cited resident:
Regarding resident #13 staff member was provided re-education to follow facilities policies and procedures to ensure staff use gait belts for all residents who require physical support for mobility or safety in transfers.

Measures put in place to ensure deficient practice does not recur:
Reeducation was provided to front line nursing staff regarding appropriate transfers, and following care plan.

Effective implementation of actions will be monitored by:
Director of Nursing or designee will perform random audits on resident transfers monthly for three months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:
The Director of Nursing or designee is responsible for maintaining compliance.

Completion date for certification purposes only is: November 21, 2021

F755-E

It is the policy of Valley View Village to document with a signature, the date, time and quantity of the narcotics given and the number of the remaining narcotics in the narcotic register with each dose given. Our policy also states that schedule 2 through schedule 5 medications are counted at the end of each shift.

Regarding cited resident:

Staff involved in the deficiency were provided reeducation to follow facilities policies and procedures to ensure staff utilized professional standards and followed policy to count narcotics every shift and document appropriately.

Measures put in place to ensure deficient practice does not recur:

Reeducation was provided to Nurses and CMA's regarding appropriate documentation of narcotic counts to ensure accurate reconciliation for all controlled medication.

Effective implementation of actions will be monitored by:

Director of Nursing or designee will perform audits of narcotic books shift counts weekly for three months. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:

The Director of Nursing or designee is responsible for maintaining compliance.

Completion date for certification purposes only is: November 21, 2021

F812-D
It is the policy of Valley View Village to distribute and serve food in accordance with professional standards for food service and safety.

Regarding cited:
Regarding resident #26 and all similar residents, reeducation was provided to front line nursing staff regarding food safety requirements.

Measures put in place to ensure deficient practice does not recur:
Reeducation was provided to nursing staff regarding food safety requirements.

Effective implementation of actions will be monitored by:
Audits of dining rooms will be done weekly for three months for compliance. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:
The Director of Nursing and Dietary Director or designees are responsible for maintaining compliance.

Completion date for certification purposes only is: November 21, 2021

F880-E
It is the policy of Valley View Village to adhere to standard precautions in all situations and wear the necessary PPE that is appropriate to specific task requirements.

Regarding cited resident:
Regarding resident's numbers, 13, 19, 64, 219, and 228, reeducation has occurred to implement standard precautions for infection control. Eye protection was implemented for resident care on 9/30/2021 during the survey process.

Measures put in place to ensure deficient practice does not recur:
Reeducation was provided to front line nursing staff regarding infection control and proper medication distribution. Staff education was provided regarding PPE, focusing on eye protection.

Effective implementation of actions will be monitored by:
Director of Nursing or designee will perform weekly checks for three months to ensure PPE is being worn as well as one random audit per week for three months to observe a medication pass to ensure staff is following infection control procedures. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended.

Those responsible to maintain compliance will be:
The Director of Nursing or designee is responsible for maintaining compliance.

Completion date for certification purposes only is: November 21, 2021