



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2026

Administrator
VALLEY VIEW MANOR HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

RE: CCN:245378
Cycle Start Date: July 9, 2026

Dear Administrator:

On July 9, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

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 October 9, 2026 (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 January 9, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

to:

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 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	
E0000	Initial Comments On 7/6/26 through 7/9/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/05/2026	
F0000	INITIAL COMMENTS On 7/6/26 through 7/9/26, a standard recertification survey (S5378044) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53783117 (2659752). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000				
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.		F0552				

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0552 SS = D	Continued from page 1 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure they had obtained and documented an informed consent, including an explanation of the risks and benefits of using a psychotropic medication or alternative treatment options for 1 of 5 residents (R4) sampled. Findings include: R4's Minimum Data Set (MDS) assessment, accepted on 7/2/26, identified his cognition was mildly impaired, he was dependent on staff to complete activities of daily living (ADL)'s, and had diagnoses of dementia, traumatic brain injury, anxiety, and depression. R4 reported feeling down, depressed, or hopeless several days during the look-back period. R4's Medication Administration Record identified the facility was administering escitalopram (an antidepressant) 5 milligrams (MG) daily for generalized anxiety starting on 12/30/25 and quetiapine (an antipsychotic) 100 mg at bedtime for unspecified dementia with agitation starting on 12/4/25. Interview and document review on 7/8/26 at 8:55 a.m., with the assistant director of nursing identified she was unable to find documentation in R8's medical record that a consent had been obtained, or			F0552	Continued from page 1 charts were reviewed and/or updated for psychotropic consent as needed. Future residents who are on psychotropic medications will have their psychotropic consent documented and uploaded into the medical record according to the facility policy. The Administrator, Social Service Designee and licensed nurses were in-serviced on the entire Antipsychotic Medication Policy with special emphasis on obtaining consent before admission and during any increases or decreases in dose amounts. Director of Nursing is responsible for compliance. Audits on consent for psychotropic use and documentation presence in the EMR 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 recommendation. Compliance: 08/05/2026		08/05/2026

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F0552 SS = D	Continued from page 2 that risks and benefits or alternative treatment options had been provided to R4 or their resident representative. Review of the facilities Antipsychotic Medication Use policy identified the facility would ensure residents only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician was to, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Residents who were admitted from the community or transferred from a hospital and who were already receiving antipsychotic medications were to be evaluated for the appropriateness and indications for use. In addition, the hospital, previous nursing home or assisted living resident record was to include the physician diagnosis, indication for use and include documentation that the resident acknowledged consent to receive prescribed psychotropic medications. Prior to starting a new psychotropic medication, the physician was to document the resident/resident representative consent in their progress notes. Medication monitoring and documentation was to include checking for side effects at least daily for the first six weeks after a resident began taking a new psychotropic medication, or a significant increase or decreased dose occurred of a currently used psychotropic medication, and at least quarterly thereafter. Minor increases or decreases in the dose of a currently used psychotropic medication did not require to be monitored as frequently as a new medication or a significant increase or decrease of a currently used psychotropic medication. In addition to appropriate physical or laboratory assessments as determined by the medically licensed person, standardized checklists or rating scales, or scales developed for a specific drug or drug class, were to be used as monitoring tools.			F0552			08/05/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints			F0605	R4 physician was contacted for GDR reduction response. R4 had a GDR completed on 7/22/2026. All current residents with pharmacy recommendations from survey exit until present were reviewed for GDR recommendations and orders were updated as needed. Future residents who meet the criteria for Gradual Dose Reductions, the facility will follow facility policy. The Administrator, Social Service Designee, DON and ADON will be in-serviced on the Gradual Dose Reduction Policy with emphasis on item #6 that if the pharmacist suggests a GDR, this information		08/05/2026

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F0605 SS = D	Continued from page 3 imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or			F0605	Continued from page 3 should be discussed by the IDT team to aid the provider or psychiatrist if medication adjustments need to occur and will review for provider response to the GDR request. Director of Nursing and/or designee is responsible for compliance. Audits on pharmacist request for GDR, was the GDR request accepted or rejected, was the GDR successful and behavior documentation if any 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 recommendation. Compliance: 08/05/2026		08/05/2026

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F0605 SS = D	Continued from page 4 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by:			F0605			08/05/2026

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F0605 SS = D	Continued from page 5 Based on interview and document review the facility failed to ensure a gradual dose reduction (GDR) was attempted, or a rationale was provided for 1 of 5 residents (R4) sampled. Findings include: R4's Minimum Data Set (MDS) assessment accepted on 7/2/26, identified his cognition was mildly impaired, he was dependent on staff to complete activities of daily living (ADL)'s and had diagnosis of dementia, traumatic brain injury, anxiety, and depression. R4 reported feeling down, depressed, or hopeless several days over past 2 weeks. R4 had no behaviors during the assessment period. Antipsychotics were received on a routine basis and a gradual dose reduction was noted to have not been attempted. R4's Medication Administration Record identified the facility was administering escitalopram (an antidepressant) 5 milligrams (MG) daily for generalized anxiety and quetiapine (an antipsychotic) 100mg at bedtime for unspecified dementia with agitation. R4's November 2025, pharmacy (RPh) medication review report identified a recommendation to the physician (MD) by the RPH to assess R4 for continued use of escitalopram and quetiapine. If the current dose is still appropriate for the patient, the RPh asked the MD to please provide the clinical rationale for continuing the current dose. The physician reviewed and accepted the report. The physician replied for R4 to continue with medication, and she would evaluate on the next nursing home rounds. His mood was noted to be stable. R4's 12/4/25, nurse practitioner (NP)-A's progress note, (completed after nursing home rounds) identified the pharmacy review was completed on 11/25/25. The quetiapine was started on 9/5/24, and the escitalopram was started on 3/28/25. NP-A noted to be questioning if the current dosing on the medications was still appropriate. A response was given to the RPh to continue "as is and will continue to monitor on routine rounds, sooner if there are acute concerns". R4's mood continued to be stable. Vitals were reviewed. No changes were recommended.			F0605			08/05/2026

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F0605 SS = D	Continued from page 6 Interview and document review on 7/8/26 at 8:55 a.m., with the assistant director of nursing (ADON) identified she searched through R4's medical record and was unable to find documentation that a GDR had been completed or that rationale for not completing a GDR had been documented. Interview on 7/8/26 at 3:12 p.m., with the director of nursing (DON) identified that they typically will get a recommendation from the RPh alerting them when a resident was due for a GDR. They also have interdisciplinary team (IDT) meetings and behavior meetings where they talk about residents and their medication and if the IDT determines a GDR or any change in medications were needed, they notify the primary physician. The DON identified she agreed that documenting "stable" and was not an appropriate rationale for continued use. She discussed it with the rounding NP and determined they need to work on a better process to make the rationale clearer. She would expect the facility to follow policy and pharmacy recommendations and follow up with the physician to ensure pharmacy recommendations are acted upon. Review of the facilities current, undated Psychotropic Medication Use policy identified residents on psychotropic medications were to receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue those medications. The policy identified the process would be completed by the IDT.			F0605			08/05/2026
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.			F0644	A PASARR review was requested for R8 by the county on 7/31/2026. All current residents' diagnosis and PASARRs were reviewed and/or updated as needed. Future residents who admit or have or had an additional serious mental diagnosis added, a new Level 2 PASARR will be requested. The Administrator, Social service designee, DON and MDS coordinator were in-serviced on the PASRR Screen Policy with emphasis on items #5 and 6 that instructs that all residents in the facility with newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred for a Level II to the appropriate state designated authority and that a Level II is required if there's a major decline or improvement in a resident's status. Social Service designee is responsible for		08/05/2026

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F0644 SS = D	Continued from page 7 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority (SMHA)) for 1 of 5 residents (R8) who had new on-set of mental illness. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment accepted on 4/22/26, identified he had diagnoses of bi-polar disorder, PTSD, and personality disorder. R8's cognition was intact, and he had not displayed any behaviors during the assessment period. R8's Pre Admission Screen (PAS) completed on 5/24/24, had a section noting if the person had a current diagnosis of mental illness to which it was documented he had a diagnosis of bi-polar disorder. There was no mention R8 had diagnoses of personality disorder or PTSD at that time. R8's diagnosis list identified he had been diagnosed with a personality disorder on 6/24/25 and PTSD on 5/28/24, both after his admission. Interview on 7/7/26 at 2:30 p.m., with the social service designee (SSD) identified she takes a "glance" at the PAS when they get a new admission to see if a level II PASARR is required but does not check for new diagnoses after admission, nor was she was aware the SMHA needed to be contacted to see if mental health services would be required. A policy was requested; however nothing was provided during the survey period.			F0644	Continued from page 7 compliance. Audits on residents identified with a new onset of mental illness 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 recommendation. Compliance: 08/05/2026		08/05/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention			F0881	R16 antibiotic therapy was reviewed for appropriateness, including indication, duration, and documentation, and appropriate interventions were implemented as indicated. The medical record was updated to reflect the clinical rationale and treatment plan. All current residents who are on antibiotics will have their orders and monitoring reviewed and		08/05/2026

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NAME OF PROVIDER OR SUPPLIER VALLEY VIEW MANOR HCC				STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152			
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F0881 SS = D	Continued from page 8 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure appropriate antibiotic use for 1 of 3 residents (R16), who were reviewed for antibiotic stewardship. Findings include: R16's 5/11/26, accepted discharge and entry Minimum Data Set (MDS) assessment identified she had severe cognitive impairment, required limited staff assistance with activities of daily living, (ADLs). She was frequently incontinent of both bowel and bladder and had diagnoses of diabetes, chronic kidney disease, and Alzheimer's disease. R16's 3/12/26 at 9:58 a.m. progress note identified the nurse practitioner (NP) had discussed the use of Macrobid (an antibiotic specifically used to treat acute, uncomplicated bladder infections (cystitis)), with R16's family member on 3/10/26 and would not recommend long-term use related to R16's age and the impact to her kidneys. R16's, 4/21/26 at 10:58 a m. NP note identified she was seen for a routine follow-up visit. The note reported she would not be ordering a chronic antibiotic for prevention of UTIs. She did provide a referral for R16 to be seen by urology if the family chose to do so, and documented R16 had only one UTI in the past 6-month period. R16's 5/4/26 at Urology consult visit note identified she was seen due to concerns with urinary incontinence, recurrent UTIs, and to be evaluated for UTIs. She had history of urinary incontinence, and difficulty with control of bladder function. The note identified UTIs were more frequent in the past and had been managed with daily antibiotics. It was noted since admission to the facility she had increased her fluid intake and reduced the frequency of UTIs. The assessment and plan identified UTIs had decreased in frequency, with recommendation for hydration and regular pad changes, to prevent infections. Recommendations were for Cranberry			F0881	Continued from page 8 updated as needed. Future residents who are prescribed antibiotic therapy will have antibiotic orders initiated and will include indication for use/diagnosis per facility policy. Facility nurses will be in-serviced on the Antibiotic Stewardship Procedure with emphasis on Antibiotic Stewardship action which instructs the nurse to record the dose, duration, route and indication of use for every antibiotic prescription, Loeb's criteria when considering initiation of antibiotics and to complete an Antibiotic "time out" to determine if antibiotic is appropriate and effective. Infection Preventionist is responsible for compliance. Audits on antibiotic dose, route, indication for use, daily documentation and 72-hr time out assessment will begin 2x a week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 08/05/2026		08/05/2026

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F0881 SS = D	Continued from page 9 tablets BID, to consider the addition of vaginal estrogen cream; toilet Q2H when awake and increase water intake with a goal of 70 ounces per day. The note identified the patient's family member was going to obtain the Cranberry tablets. Urinary incontinence was reported as likely related to cognitive decline and medications. Risks and benefits of bladder medications were discussed, and a medication trial was deferred. Recommendation was to continue scheduled toileting every 2 hours and maintain adequate fluid intake. R16 and her family member voiced agreement with the discussed plan. R16's 5/17/26 at 4:39 p.m. physician visit note listed, "I understand will she be able to come in to see me. I would love to give her antibiotics once a day to prevent a bladder infection. Let nursing home [facility] know Macrobid 100 mg q am q day ". R16's 5/18/26 at 12:52 p.m. progress note identified R16 was hospitalized 5/5/26 through 5/11/26 with a principal diagnosis of Septic shock complicated secondary to acute cystitis (inflammation of the bladder) and complicated by Escherichia coli (a normal part of the gut flora, with the most common infection from a urinary tract infection(UTI), chronic kidney disease, acute kidney injury, acute cystitis with hematuria (blood in the urine), and gram-negative bacteremia (the presence of Gram-negative bacteria in the bloodstream). She was discharged back to the facility with an order for Ciprofloxacin (an antibiotic used to treat severe bacterial infections), 500 milligrams (mg) by mouth (PO) two times daily (BID) before meals, for four days. She also had an order for Cranberry 500mg BID for history of UTIs. She was to be toileted regularly and follow-up appointments were scheduled. R16's 5/21/26 physician order from physician (MD-A) identified Macrobid 100 milligrams (mg) (antibiotic) by mouth PO every (Q) morning (a.m.). No end date or date for reassessment of need for antibiotic was included. Interview on 7/8/26 at 9:08 a.m. with the infection preventionist (IP) reported the facility continued to have issues with medical staff completing antibiotic time outs and continuing to order antibiotics even if the criteria was not met. She identified R16 and had 6 months of no recurrent UTIs following admission.			F0881			08/05/2026

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F0881 SS = D	Continued from page 10 She had a history of recurrent UTIs when living in an assisted living situation, and it was thought the recurrent UTIs were likely a result of poor perineal hygiene after toileting. Her family wanted her to continue an antibiotic as a preventative measure even though she had no signs or symptoms. Education was provided by both nursing staff and the NP, but family continued to request orders for a prophylactic antibiotic. R16 was also seen by Urology and education was provided to both the family and patient that antibiotic was not indicated related to the potential for kidney injury. The IP reported R16's family then contacted a different MD, who agreed to order a prophylactic antibiotic for the prevention of UTIs. She reported R16 was now experiencing increased peripheral edema felt to be a side effect of the ordered antibiotic. The MD was notified of the peripheral edema but continued to order the antibiotic, even though R16 had no signs or symptoms of a UTI, and there was no identified date to stop the antibiotic for evaluation of need. The IP reported the medical director was aware of the situation, but there was no resolution at the time of interview. Attempted interview with MD-A was made on 7/8/26 at 3:50 p.m. with a request for a return call. As return call was not received. Interview on 7/9/26 at 9:11 a.m., with the pharmacist (RPh) identified R16s medical record lacked documentation to justify prophylactic antibiotic use, and confirmed the order had an order date of 5/21/26, with no end date, nor a date for re assessment of need. She reported her expectation was for Antibiotic Stewardship criteria to be followed, and she had not addressed the issue in her June review but would request documentation for a risk verses benefit to be documented every 6 months. Interview on 7/8/26 at 4:30 p.m. with the director of nursing identified her expectation for antibiotic stewardship practices to be followed according to facility policy and the identified area of concern with R16 would need to be evaluated further. Review of the 10/4/21 Antibiotic Stewardship Policy identified a concentrated effort to decrease or eliminate unnecessary use of antibiotics for resident safety and to avoid unnecessary side effects.			F0881			08/05/2026

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F0881 SS = D	Continued from page 11 The seven identified elements of the Antibiotic Stewardship Program included: 1. Leadership Commitment 2. Accountability: Physician, nursing and pharmacy are responsible for promoting and overseeing antibiotic stewardship. 3. Drug Expertise: Identified by the consultant pharmacist. 4. Action: Implantation of policies and procedures for antibiotic use. 5. Tracking: Monitoring of antibiotic use with outcomes documented. 6. Reporting: Feedback to medical staff, nursing, and relevant staff on antibiotic use and any resistance to antibiotic stewardship practices. 7. Education: provision of antibiotic stewardship information to medical staff, nursing, residents and families on the need for antibiotic stewardship practices related to use of antibiotics. Prescribers were to base their treatment recommendations on likely UTI site, facility-specific culture with antibiotic sensitivity data, patient-specific data including age, prior antibiotic use, allergies, concomitant drug therapy, renal function and presence of a urinary catheter. The antibiotic stewardship team was directed to monitor the use of antibiotics, identify potential inappropriate use of an antibiotic for specific syndromes or prophylactic use to guide practice changes, and track any impact to residents.			F0881			08/05/2026

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E0000	Initial Comments On 7/6/26 through 7/9/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			08/05/2026	
F0000	INITIAL COMMENTS On 7/6/26 through 7/9/26, a standard recertification survey (S5378044) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53783117 (2659752). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000				08/05/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.			F0552				

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0552 SS = D	Continued from page 1 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure they had obtained and documented an informed consent, including an explanation of the risks and benefits of using a psychotropic medication or alternative treatment options for 1 of 5 residents (R4) sampled. Findings include: R4's Minimum Data Set (MDS) assessment, accepted on 7/2/26, identified his cognition was mildly impaired, he was dependent on staff to complete activities of daily living (ADL)'s, and had diagnoses of dementia, traumatic brain injury, anxiety, and depression. R4 reported feeling down, depressed, or hopeless several days during the look-back period. R4's Medication Administration Record identified the facility was administering escitalopram (an antidepressant) 5 milligrams (MG) daily for generalized anxiety starting on 12/30/25 and quetiapine (an antipsychotic) 100 mg at bedtime for unspecified dementia with agitation starting on 12/4/25. Interview and document review on 7/8/26 at 8:55 a.m., with the assistant director of nursing identified she was unable to find documentation in R8's medical record that a consent had been obtained, or			F0552	Continued from page 1 charts were reviewed and/or updated for psychotropic consent as needed. Future residents who are on psychotropic medications will have their psychotropic consent documented and uploaded into the medical record according to the facility policy. The Administrator, Social Service Designee and licensed nurses were in-serviced on the entire Antipsychotic Medication Policy with special emphasis on obtaining consent before admission and during any increases or decreases in dose amounts. Director of Nursing is responsible for compliance. Audits on consent for psychotropic use and documentation presence in the EMR 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 recommendation. Compliance: 08/12/2026		08/12/2026

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F0552 SS = D	Continued from page 2 that risks and benefits or alternative treatment options had been provided to R4 or their resident representative. Review of the facilities Antipsychotic Medication Use policy identified the facility would ensure residents only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician was to, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Residents who were admitted from the community or transferred from a hospital and who were already receiving antipsychotic medications were to be evaluated for the appropriateness and indications for use. In addition, the hospital, previous nursing home or assisted living resident record was to include the physician diagnosis, indication for use and include documentation that the resident acknowledged consent to receive prescribed psychotropic medications. Prior to starting a new psychotropic medication, the physician was to document the resident/resident representative consent in their progress notes. Medication monitoring and documentation was to include checking for side effects at least daily for the first six weeks after a resident began taking a new psychotropic medication, or a significant increase or decreased dose occurred of a currently used psychotropic medication, and at least quarterly thereafter. Minor increases or decreases in the dose of a currently used psychotropic medication did not require to be monitored as frequently as a new medication or a significant increase or decrease of a currently used psychotropic medication. In addition to appropriate physical or laboratory assessments as determined by the medically licensed person, standardized checklists or rating scales, or scales developed for a specific drug or drug class, were to be used as monitoring tools.			F0552			08/12/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints			F0605	R4 physician was contacted for GDR reduction response. R4 had a GDR completed on 7/22/2026. All current residents with pharmacy recommendations from survey exit until present were reviewed for GDR recommendations and orders were updated as needed. Future residents who meet the criteria for Gradual Dose Reductions, the facility will follow facility policy. The Administrator, Social Service Designee, DON and ADON will be in-serviced on the Gradual Dose Reduction Policy with emphasis on item #6 that if the pharmacist suggests a GDR, this information		08/12/2026

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F0605 SS = D	Continued from page 3 imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or			F0605	Continued from page 3 should be discussed by the IDT team to aid the provider or psychiatrist if medication adjustments need to occur and will review for provider response to the GDR request. Director of Nursing and/or designee is responsible for compliance. Audits on pharmacist request for GDR, was the GDR request accepted or rejected, was the GDR successful and behavior documentation if any 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 recommendation. Compliance: 08/12/2026		08/12/2026

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F0605 SS = D	Continued from page 4 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by:			F0605			08/12/2026

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F0605 SS = D	Continued from page 5 Based on interview and document review the facility failed to ensure a gradual dose reduction (GDR) was attempted, or a rationale was provided for 1 of 5 residents (R4) sampled. Findings include: R4's Minimum Data Set (MDS) assessment accepted on 7/2/26, identified his cognition was mildly impaired, he was dependent on staff to complete activities of daily living (ADL)'s and had diagnosis of dementia, traumatic brain injury, anxiety, and depression. R4 reported feeling down, depressed, or hopeless several days over past 2 weeks. R4 had no behaviors during the assessment period. Antipsychotics were received on a routine basis and a gradual dose reduction was noted to have not been attempted. R4's Medication Administration Record identified the facility was administering escitalopram (an antidepressant) 5 milligrams (MG) daily for generalized anxiety and quetiapine (an antipsychotic) 100mg at bedtime for unspecified dementia with agitation. R4's November 2025, pharmacy (RPh) medication review report identified a recommendation to the physician (MD) by the RPH to assess R4 for continued use of escitalopram and quetiapine. If the current dose is still appropriate for the patient, the RPh asked the MD to please provide the clinical rationale for continuing the current dose. The physician reviewed and accepted the report. The physician replied for R4 to continue with medication, and she would evaluate on the next nursing home rounds. His mood was noted to be stable. R4's 12/4/25, nurse practitioner (NP)-A's progress note, (completed after nursing home rounds) identified the pharmacy review was completed on 11/25/25. The quetiapine was started on 9/5/24, and the escitalopram was started on 3/28/25. NP-A noted to be questioning if the current dosing on the medications was still appropriate. A response was given to the RPh to continue "as is and will continue to monitor on routine rounds, sooner if there are acute concerns". R4's mood continued to be stable. Vitals were reviewed. No changes were recommended.			F0605			08/12/2026

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NAME OF PROVIDER OR SUPPLIER Valley View Manor Healthcare Center				STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 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
F0605 SS = D	Continued from page 6 Interview and document review on 7/8/26 at 8:55 a.m., with the assistant director of nursing (ADON) identified she searched through R4's medical record and was unable to find documentation that a GDR had been completed or that rationale for not completing a GDR had been documented. Interview on 7/8/26 at 3:12 p.m., with the director of nursing (DON) identified that they typically will get a recommendation from the RPh alerting them when a resident was due for a GDR. They also have interdisciplinary team (IDT) meetings and behavior meetings where they talk about residents and their medication and if the IDT determines a GDR or any change in medications were needed, they notify the primary physician. The DON identified she agreed that documenting "stable" and was not an appropriate rationale for continued use. She discussed it with the rounding NP and determined they need to work on a better process to make the rationale clearer. She would expect the facility to follow policy and pharmacy recommendations and follow up with the physician to ensure pharmacy recommendations are acted upon. Review of the facilities current, undated Psychotropic Medication Use policy identified residents on psychotropic medications were to receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue those medications. The policy identified the process would be completed by the IDT.			F0605			08/12/2026
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.			F0644	A PASARR review was requested for R8 by the county on 7/31/2026. All current residents' diagnosis and PASARRs were reviewed and/or updated as needed. Future residents who admit or have or had an additional serious mental diagnosis added, a new Level 2 PASARR will be requested. The Administrator, Social service designee, DON and MDS coordinator were in-serviced on the PASRR Screen Policy with emphasis on items #5 and 6 that instructs that all residents in the facility with newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred for a Level II to the appropriate state designated authority and that a Level II is required if there's a major decline or improvement in a resident's status. Social Service designee is responsible for		08/12/2026

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F0644 SS = D	Continued from page 7 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority (SMHA)) for 1 of 5 residents (R8) who had new on-set of mental illness. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment accepted on 4/22/26, identified he had diagnoses of bi-polar disorder, PTSD, and personality disorder. R8's cognition was intact, and he had not displayed any behaviors during the assessment period. R8's Pre Admission Screen (PAS) completed on 5/24/24, had a section noting if the person had a current diagnosis of mental illness to which it was documented he had a diagnosis of bi-polar disorder. There was no mention R8 had diagnoses of personality disorder or PTSD at that time. R8's diagnosis list identified he had been diagnosed with a personality disorder on 6/24/25 and PTSD on 5/28/24, both after his admission. Interview on 7/7/26 at 2:30 p.m., with the social service designee (SSD) identified she takes a "glance" at the PAS when they get a new admission to see if a level II PASARR is required but does not check for new diagnoses after admission, nor was she was aware the SMHA needed to be contacted to see if mental health services would be required. A policy was requested; however nothing was provided during the survey period.			F0644	Continued from page 7 compliance. Audits on residents identified with a new onset of mental illness 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 recommendation. Compliance: 08/12/2026		08/12/2026
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention			F0881	R16 antibiotic therapy was reviewed for appropriateness, including indication, duration, and documentation, and appropriate interventions were implemented as indicated. The medical record was updated to reflect the clinical rationale and treatment plan. All current residents who are on antibiotics will have their orders and monitoring reviewed and		08/12/2026

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F0881 SS = D	Continued from page 8 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure appropriate antibiotic use for 1 of 3 residents (R16), who were reviewed for antibiotic stewardship. Findings include: R16's 5/11/26, accepted discharge and entry Minimum Data Set (MDS) assessment identified she had severe cognitive impairment, required limited staff assistance with activities of daily living, (ADLs). She was frequently incontinent of both bowel and bladder and had diagnoses of diabetes, chronic kidney disease, and Alzheimer's disease. R16's 3/12/26 at 9:58 a.m. progress note identified the nurse practitioner (NP) had discussed the use of Macrobid (an antibiotic specifically used to treat acute, uncomplicated bladder infections (cystitis)), with R16's family member on 3/10/26 and would not recommend long-term use related to R16's age and the impact to her kidneys. R16's, 4/21/26 at 10:58 a m. NP note identified she was seen for a routine follow-up visit. The note reported she would not be ordering a chronic antibiotic for prevention of UTIs. She did provide a referral for R16 to be seen by urology if the family chose to do so, and documented R16 had only one UTI in the past 6-month period. R16's 5/4/26 at Urology consult visit note identified she was seen due to concerns with urinary incontinence, recurrent UTIs, and to be evaluated for UTIs. She had history of urinary incontinence, and difficulty with control of bladder function. The note identified UTIs were more frequent in the past and had been managed with daily antibiotics. It was noted since admission to the facility she had increased her fluid intake and reduced the frequency of UTIs. The assessment and plan identified UTIs had decreased in frequency, with recommendation for hydration and regular pad changes, to prevent infections. Recommendations were for Cranberry			F0881	Continued from page 8 updated as needed. Future residents who are prescribed antibiotic therapy will have antibiotic orders initiated and will include indication for use/diagnosis per facility policy. Facility nurses will be in-serviced on the Antibiotic Stewardship Procedure with emphasis on Antibiotic Stewardship action which instructs the nurse to record the dose, duration, route and indication of use for every antibiotic prescription, Loeb's criteria when considering initiation of antibiotics and to complete an Antibiotic "time out" to determine if antibiotic is appropriate and effective. Infection Preventionist is responsible for compliance. Audits on antibiotic dose, route, indication for use, daily documentation and 72-hr time out assessment will begin 2x a week for 2 weeks, weekly x 2 weeks, then monthly to ensure sustained compliance. Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation. Compliance: 08/12/2026		08/12/2026

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F0881 SS = D	Continued from page 9 tablets BID, to consider the addition of vaginal estrogen cream; toilet Q2H when awake and increase water intake with a goal of 70 ounces per day. The note identified the patient's family member was going to obtain the Cranberry tablets. Urinary incontinence was reported as likely related to cognitive decline and medications. Risks and benefits of bladder medications were discussed, and a medication trial was deferred. Recommendation was to continue scheduled toileting every 2 hours and maintain adequate fluid intake. R16 and her family member voiced agreement with the discussed plan. R16's 5/17/26 at 4:39 p.m. physician visit note listed, "I understand will she be able to come in to see me. I would love to give her antibiotics once a day to prevent a bladder infection. Let nursing home [facility] know Macrobid 100 mg q am q day ". R16's 5/18/26 at 12:52 p.m. progress note identified R16 was hospitalized 5/5/26 through 5/11/26 with a principal diagnosis of Septic shock complicated secondary to acute cystitis (inflammation of the bladder) and complicated by Escherichia coli (a normal part of the gut flora, with the most common infection from a urinary tract infection(UTI), chronic kidney disease, acute kidney injury, acute cystitis with hematuria (blood in the urine), and gram-negative bacteremia (the presence of Gram-negative bacteria in the bloodstream). She was discharged back to the facility with an order for Ciprofloxacin (an antibiotic used to treat severe bacterial infections), 500 milligrams (mg) by mouth (PO) two times daily (BID) before meals, for four days. She also had an order for Cranberry 500mg BID for history of UTIs. She was to be toileted regularly and follow-up appointments were scheduled. R16's 5/21/26 physician order from physician (MD-A) identified Macrobid 100 milligrams (mg) (antibiotic) by mouth PO every (Q) morning (a.m.). No end date or date for reassessment of need for antibiotic was included. Interview on 7/8/26 at 9:08 a.m. with the infection preventionist (IP) reported the facility continued to have issues with medical staff completing antibiotic time outs and continuing to order antibiotics even if the criteria was not met. She identified R16 and had 6 months of no recurrent UTIs following admission.			F0881			08/12/2026

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F0881 SS = D	Continued from page 10 She had a history of recurrent UTIs when living in an assisted living situation, and it was thought the recurrent UTIs were likely a result of poor perineal hygiene after toileting. Her family wanted her to continue an antibiotic as a preventative measure even though she had no signs or symptoms. Education was provided by both nursing staff and the NP, but family continued to request orders for a prophylactic antibiotic. R16 was also seen by Urology and education was provided to both the family and patient that antibiotic was not indicated related to the potential for kidney injury. The IP reported R16's family then contacted a different MD, who agreed to order a prophylactic antibiotic for the prevention of UTIs. She reported R16 was now experiencing increased peripheral edema felt to be a side effect of the ordered antibiotic. The MD was notified of the peripheral edema but continued to order the antibiotic, even though R16 had no signs or symptoms of a UTI, and there was no identified date to stop the antibiotic for evaluation of need. The IP reported the medical director was aware of the situation, but there was no resolution at the time of interview. Attempted interview with MD-A was made on 7/8/26 at 3:50 p.m. with a request for a return call. As return call was not received. Interview on 7/9/26 at 9:11 a.m., with the pharmacist (RPh) identified R16s medical record lacked documentation to justify prophylactic antibiotic use, and confirmed the order had an order date of 5/21/26, with no end date, nor a date for re assessment of need. She reported her expectation was for Antibiotic Stewardship criteria to be followed, and she had not addressed the issue in her June review but would request documentation for a risk verses benefit to be documented every 6 months. Interview on 7/8/26 at 4:30 p.m. with the director of nursing identified her expectation for antibiotic stewardship practices to be followed according to facility policy and the identified area of concern with R16 would need to be evaluated further. Review of the 10/4/21 Antibiotic Stewardship Policy identified a concentrated effort to decrease or eliminate unnecessary use of antibiotics for resident safety and to avoid unnecessary side effects.			F0881			08/12/2026

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F0881 SS = D	Continued from page 11 The seven identified elements of the Antibiotic Stewardship Program included: 1. Leadership Commitment 2. Accountability: Physician, nursing and pharmacy are responsible for promoting and overseeing antibiotic stewardship. 3. Drug Expertise: Identified by the consultant pharmacist. 4. Action: Implantation of policies and procedures for antibiotic use. 5. Tracking: Monitoring of antibiotic use with outcomes documented. 6. Reporting: Feedback to medical staff, nursing, and relevant staff on antibiotic use and any resistance to antibiotic stewardship practices. 7. Education: provision of antibiotic stewardship information to medical staff, nursing, residents and families on the need for antibiotic stewardship practices related to use of antibiotics. Prescribers were to base their treatment recommendations on likely UTI site, facility-specific culture with antibiotic sensitivity data, patient-specific data including age, prior antibiotic use, allergies, concomitant drug therapy, renal function and presence of a urinary catheter. The antibiotic stewardship team was directed to monitor the use of antibiotics, identify potential inappropriate use of an antibiotic for specific syndromes or prophylactic use to guide practice changes, and track any impact to residents.			F0881			08/12/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/07/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Valley View Manor Hcc was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/05/2026

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 reverse for further 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.

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Valley View Manor Hcc was constructed in 1972, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st Addition was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 2nd Addition was constructed in 1989, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 3rd Addition was constructed in 1999, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(000) construction. The facility has a capacity of 50 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT			K0000			08/05/2026

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K0000 Bldg. 01	Continued from page 2 MET as evidenced by:			K0000			08/05/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection records and safety measures associated with cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.2.3. and NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations section 11.2.1 This deficient practice could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 9:01 AM, it was revealed by documentation review and staff interview that the facility was not inspecting the kitchen fire suppression system every six months. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	Corrective Action: The kitchen fire suppression system inspection was completed by the facility's licensed vendor on 7/13/26. Documentation of the required semi-annual inspection has been obtained and placed in the Life Safety compliance binder. Systemic Changes: A preventive maintenance schedule has been updated to include semi-annual kitchen suppression system inspections with automatic reminders prior to each due date. Monitoring: The Maintenance Director will review the Life Safety compliance calendar monthly to verify inspections remain current and documentation is maintained. Responsible Party: Maintenance Director		08/05/2026

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K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.2.1.2.2, 14.3.1, 14.4.5, and 14.4.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 07/07/2026 at 9:59 AM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review. 2. On 07/07/2026 at 10:33 AM, it was revealed by observation that the Fire Alarm Control Panel was in trouble mode. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.			K0345	Corrective Action: The fire alarm vendor was contacted to provide the required detector sensitivity testing report and to evaluate and correct the fire alarm control panel trouble condition. Documentation of repairs and testing will be maintained on-site. Dates of Service: 7/13/26 and 8/3/26 Systemic Changes: The facility's preventive maintenance program has been revised to ensure all required annual fire alarm testing reports are obtained and reviewed following each inspection. Monitoring: The Maintenance Director will conduct monthly reviews of the fire alarm panel status and Life Safety documentation to ensure continued compliance. Responsible Party: Maintenance Director		08/05/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both			K0914	Corrective Action: Required resident room electrical receptacle testing has been completed. Updated testing documentation will be maintained within the Life Safety records. Systemic Changes: Electrical receptacle testing has been incorporated into the facility's preventive maintenance schedule to ensure testing is completed within required intervals. Monitoring: The Maintenance Director will review electrical testing documentation annually to verify compliance.		08/05/2026

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K0914 SS = F Bldg. 01	Continued from page 4 visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 9:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide updated documentation for resident room electrical receptacle testing. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.			K0914	Continued from page 4 Responsible Party: Maintenance Director		08/05/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel.			K0918	Corrective Action: The required letter of reliability for the natural gas service supporting the emergency generator was found from the utility company and will be maintained with generator documentation. Systemic Changes: Generator documentation requirements have been added to the facility's annual Life Safety compliance checklist. Monitoring: The Maintenance Director will verify annually that all required generator documentation remains current. Responsible Party: Maintenance Director		08/05/2026

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K0918 SS = F Bldg. 01	Continued from page 5 Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 4.2. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 07/07/2026 at 9:52 AM, it was revealed by a review of available documentation at the time of the survey the facility could not provide a letter of reliability from the gas company. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.			K0918			08/05/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and			K0921	Waiver being requested. Maintenance Director will not have ability to complete all PECREE testing by the compliance date for Life Safety Survey and Annual Health Survey.		08/05/2026

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K0921 SS = F Bldg. 01	Continued from page 6 procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain Patient Care Related Electrical Equipment per NFPA 99 (2012 edition), Health Care Facilities Code. Sections 10.3, 10.5.2, 10.5.2.1.2 and 10.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 10:55 AM, it was revealed by a review of available documentation and staff interview that the facility could not provide documentation showing that Patient-Care Related Electrical Equipment (PCREE) had been inspected within the last year. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.			K0921			08/05/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms			K0920	Corrective Action: The refrigerator was immediately removed from the power strip and plugged directly into a wall receptacle. The extension cord used for the nurse's office time clock was removed and the device relocated to a permanent electrical outlet. Systemic Changes: Facility staff have been educated regarding appropriate use of power strips and the prohibition of extension cords as permanent wiring. Monitoring: The Maintenance Director will complete monthly		08/05/2026

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K0920 SS = D Bldg. 01	Continued from page 7 (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a isolated impact on the residents within the facility. Findings include: 1. On 07/07/2026 at 10:08 AM, it was revealed by observation that the refrigerator in the Maintenance office was plugged into a power strip. 2. On 07/07/2026 at 10:39 AM, it was revealed by observation that the time clock in the Nurse's Office was plugged into a blue extension cord. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.			K0920	Continued from page 7 environmental rounds to monitor for improper use of extension cords and power strips. Responsible Party: Maintenance Director		08/05/2026
K0363 SS = A Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that			K0363			08/05/2026

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K0363 SS = A Bldg. 01	Continued from page 8 do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 07/07/2026 at 10:37 AM, it was revealed by observation the door to the Dietary Office was propped open with a rubber wedge. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.			K0363			08/05/2026