DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 26, 2025

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

RE: CCN: 245566
Cycle Start Date: May 29, 2025

Dear Administrator:

On June 24, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2025

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

RE: CCN: 245566
Cycle Start Date: May 29, 2025

Dear Administrator:

On May 29, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 29, 2025 (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 November 29, 2025 (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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING _____ B. WING _____	C 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 5/27/25-5/29/25, a survey for compliance with §483.73 Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 020		5/29/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2025

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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	245566	A. BUILDING _____ B. WING _____	C 05/29/2025

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VALLEY VIEW HEALTHCARE & REHAB	510 EAST CEDAR STREET HOUSTON, MN 55943

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E 020	Continued From page 1 [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	E 020	E020 Policies for Evac. and Primary/Alt.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 020	Continued From page 2 facility failed to ensure the comprehensive Emergency Preparedness Plan (EPP) included information demonstrating adequate evacuation procedures, including how to address resident refusals to evacuate. This had the potential to affect all 30 residents residing in the facility. Findings include: Valley View Care Center was licensed for 45 nursing home beds with an average daily census of 27-30 persons. The facility cared for numerous medical diagnoses including mood disorders, pneumonia, digestive disorders, skin disorders, infectious diseases, neurological disorders, end-of-life care, and vision and hearing impaired. During the recertification survey from 5/27/25 to 5/29/25, the EPP was provided and reviewed. The EPP was last reviewed on 3/6/25 and contained in a white-colored binder which outlined each of the respective policies, procedures, and processes for emergency situations and the facility' corresponding response. The EPP included a General Evacuation Plan which listed several potential reasons to evacuate the building including smoke, fire, toxic fumes, and structural damage due to nature disaster. The plan listed various facility-based positions (i.e., administrator, charge nurse) along with their corresponding duties in such an evacuation. However, the plan and the EPP in its entirety lacked procedures or policies demonstrating how a resident refusal to evacuate would be handled or addressed to ensure their safety as best able. On 5/29/25 at 10:23 a.m., the administrator was interviewed. The administrator explained she	E 020	Comm. CFR(s): 483.73(b)(3) A policy entitled “Valley View Healthcare & Rehab Emergency Preparedness Policy for Non-Evacuating Residents” was created on May 29, 2025 and added to the Emergency Preparedness binders. The policy includes processes and procedures for residents that refuse to evacuate during a declared emergency. In addition, an Evacuation Refusal form was created to outline steps that have been taken to encourage resident evacuation and safety. The policy will be reviewed at least annually as part of the Emergency Preparedness plan review. The new policy and refusal form will be reviewed at the next scheduled QAPI meeting.	

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E 020	Continued From page 3 worked to manage the EPP and verified the entire plan was last reviewed on 3/6/25. The administrator stated the provided evacuation plan did "not currently" outline how-to act on or address resident refusals to evacuate. Safe evacuation from the Valley View Care Center, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 020		
F 000	INITIAL COMMENTS On 5/27/25-5/29/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited. : H55665450C (MN00112918). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**05/28/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/28/2025. At the time of this survey, VALLEY VIEW HEALTHCARE AND REHAB 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/10/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. VALLEY VIEW HEALTHCARE AND REHAB is a 1 story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1957, with additions following in 1976, 1988, and 2011. All to be determined as Type II (111). The original building and all additions have no basement. Because the original building and addition meet	K 000		

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K 000	Continued From page 2 the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, that is monitored for automatic fire department notification. There is an assisted living facility which is separated from the nursing home by a 2-hour fire separation. The facility has a capacity of 35 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a fire alarm	K 346	K346 Fire Alarm System - Out of Service CFR(s): NFPA 101	6/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 346	Continued From page 3 out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/09/2024 between 10:30 AM and 12:30 PM, it was revealed by a review of available documentation that the fire alarm out-of-service policy did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 346	The Fire Alarm Systems Out of Service policy has been updated to reflect current contact information, including contacting the State Fire Marshall Division if the fire alarm system is out of service for more than 4 hours in a 24-hour period. In addition, all contact information and procedures have been updated. The Maintenance Supervisor is responsible for the policy and notification of policy revisions. The new policy will be included in the Emergency Preparedness Binder in conjunction with the Fire Safety Section. The Fire Alarm Systems out of Service policy will be updated and reviewed annually or as needed. The new policy will be reviewed at the next scheduled QAPI meeting.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		6/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 4 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/09/2024 at 12:40 PM, it was revealed by observation in the Kitchen (adjacent to range hood) the sprinkler head exhibited sign of debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	K353 Sprinkler System – Maintenance and Testing CFR(s): NFPA 101 Sprinkler heads adjacent to the range hood system in the kitchen were inspected for debris. The maintenance supervisor, Dean Johnson, cleaned the sprinkler head adjacent to the range hood system that was noted to have sign of debris on 06/09/2025. The kitchen sprinkler heads adjacent to the range hood system will be inspected monthly by the maintenance director or as needed to ensure they are clear of debris. Sprinkler head cleaning logs will be reviewed at the next three QAPI meetings.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the	K 354		6/10/25

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	245566	A. BUILDING **01 - VALLEY VIEW NURSING HOME** B. WING _____	**05/28/2025**

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

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K 354	Continued From page 5 sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on available documentation and staff interview, the facility failed to maintain a sprinkler system out of service policy per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1, 9.7.5, 9.7.6 and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2(6). This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/09/2024 between 10:30 AM and 12:30 PM, it was revealed by a review of available documentation that the fire sprinkler system out-of-service policy did not include in the notification listing the MN Department of Public Safety - Fire Marshal Division (point of contact and phone #). An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 354	K354 Sprinkler System – Out of Service CFR(s): NFPA 101 The Sprinkler System Out of Service policy has been updated to reflect current contact information, including contacting the State Fire Marshall Division if the Sprinkler system is out of service for more than 10 hours in a 24-hour period. In addition, all contact information and procedures have been updated. The Maintenance Supervisor is responsible for the policy and notification of policy revisions. The new policy will be included in the Emergency Preparedness Binder in conjunction with the Fire Safety Section. The Sprinkler Systems out of Service policy will be updated and reviewed annually or as needed. The new policy will be reviewed at the next scheduled QAPI meeting.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374		6/10/25

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K 374	Continued From page 6 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 Theis deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/09/2024 at 12:50 PM, it was revealed by observation that the fire / smoke door assembly (B), upon test did not close and seal the opening exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	K374 Subdivision of Building Spaces -Smoke Barrier CFR(s): NFPA 101 On 06-09-2025 maintenance supervisor, Dean Johnson, added additional smoke strip to bridge the air gap in the smoke barrier door that exhibited an air-gap greater than 1/8 inch. Fire doors are inspected annually by the maintenance supervisor. Maintenance supervisor will re-check smoke barrier doors at the time of the monthly fire drill. The Fire drill reports will be reviewed at the next three scheduled meetings.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		6/10/25

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K 918	Continued From page 7 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. 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain notification device(s) associated to the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.16, 6.4.1.1.16.2 and NFPA 110 (2010 edition) 5.6.6.	K 918	K918 Electrical Systems – Essential Electric System CFR(s): NFPA 101 On 06/02/2025, Interstate Power Systems came onsite to replace the bad chip (circuit board) on the annunciator panel.	

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K 918	Continued From page 8 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/09/2024 at 1:00 PM, it was revealed by observation during the remote generator annunciator panel located at the Nurses Station, equipped with audible alarm, did not function upon testing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	The annunciator panel will be tested biannually as part of the routine generator inspection schedule. Any faults or deficiencies in activation and functionality will be corrected upon discovery. The maintenance supervisor will add to his monthly generator inspection log, a section that includes ensuring the annunciator panels green light is illuminated. Any faults or deficiencies will be reported immediately to Interstate Power Systems. The monthly generator inspection log will be reviewed at the next three scheduled QAPI meetings.	
K 920 SS=D	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) assembles 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 (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	K 920		6/10/25

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K 920	Continued From page 9 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/09/2024 at 1:15 PM, it was revealed by observation that in the Director of Nursing Office relocatable power taps were found daisy-chained and in use. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 Electrical Equipment – Power Cords and Extension Cords CFR(s): NFPA 101 The power cords that were daisy chained in the Director of Nursing office were remedied on 05-28-2025. One of the cords was removed from service. A single UL certified cord was plugged directly into the wall outlet, with ancillary items being plugged directly into the single UL Certified power strip. The power cord/extension cord policy was revised on 05/25/2025. The new policy will be reviewed at the next scheduled QAPI meeting.	