



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2026

Administrator
Valley View Manor HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

RE: CCN: 245378

Cycle Start Date: [Custom Date Prompt (Words)](Enter Survey Cycle Start Date)]

Dear Administrator:

On May 1, 2026, we notified you a remedy was imposed. On May 27, 2026, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 12, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 16, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 1, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 20, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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

Office: 651-201-4112



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 30, 2026

Administrator
Valley View Manor HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

Re: Reinspection Results
Event ID: 22EAAD-H2

Dear Administrator:

On May 27, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 20, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

May 1, 2026

Administrator
Valley View Manor HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

RE: CCN: 245378

Cycle Start Date: April 20, 2026

Dear Administrator:

On April 20, 2026, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On April 17, 2026, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedies listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 16, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 16, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 16, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 20, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Valley View Manor HCC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 20, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office

3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 20, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file

electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 1, 2026

Administrator
Valley View Manor HCC
200 EAST NINTH AVENUE
LAMBERTON, MN 56152

Re: State Nursing Home Licensing Orders
Event ID: 22EAAD-H1

Dear Administrator:

The above facility survey was completed on April 20, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
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 04/20/2026
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
F0000	<p>INITIAL COMMENTS</p> <p>On 4/15/26, 4/16/26, 4/20/26 a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities.</p> <p>The survey resulted in immediate jeopardy (IJ) to resident health and safety. The IJ began on 4/13/26 after R1 left the facility unsupervised at around 5:00 a.m. and was located 5-6 blocks away walking in the middle of the street. The administrator and director of nursing (DON) were notified of the IJ on 4/16/26 at 5:04 p.m. Immediate jeopardy was removed on 4/17/26 at 5:00 p.m.</p> <p>The above findings constituted Substandard Quality of Care and an extended survey was conducted on 4/20/26.</p> <p>The following complaints were reviewed: H53781259C (2982217) with a deficiencies cited at F689 at IJ and F656</p> <p>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.</p>	F0000		05/12/2026
F0689 SS = SQC-J	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate</p>	F0689	<p>R1 has since been discharged from the facility. R4 and R6 were assessed for elopement, and their orders and care plan were reviewed and updated. All current residents were assessed for elopement, and their orders and care plans were reviewed and updated as needed. Future residents who admit they will be assessed for the risk for elopement, and their orders and care plans and interventions will be initiated per facility policy.</p> <p>Facility staff were in-serviced on the Safety/Supervision of Resident Policy with emphasis on ensuring that there is a resident centered</p>	05/12/2026

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
---	-------	-----------

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 1 supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to ensure appropriate interventions were in place to prevent elopement for 3 of 3 residents (R1, R4, R6) who were identified as an elopement risk. This resulted in immediate jeopardy (IJ) for R1 when she was able to leave the facility when it was dark and foggy outside and was able to walk 5-6 blocks away before being found, which put R1 at likelihood for serious harm or death.</p> <p>The IJ began on 4/13/26 when R1 was able to elope from the facility after the facility failed to complete a comprehensive assessment for individualized interventions and level of supervision after R1 removed, then refused, replacement of Wanderguard (personal alarming safety device) on 3/29/26 and continued to display exit seeking behaviors. Additionally, the facility failed to identify and implement individualized interventions to prevent and/or mitigate risk for elopement for R4 and R6. On 4/16/26 at 5:04 p.m., the administrator, director of nursing, and vice president of clinical services were notified of the IJ. The IJ was removed on 4/17/26 at 5:00 p.m., after it was verified, the facility implemented an acceptable removal plan. However, non-compliance remained at a lower scope and severity of no actual harm, with a potential for more than minimal harm.</p> <p>Findings include:</p> <p>R1's face sheet dated 4/15/26, identified diagnoses of unspecified dementia without behavioral disturbance and depression.</p> <p>R1's neurology note dated 3/10/26, identified R1 was seen for a follow up on cognitive changes where her neuropsychometric (a comprehensive evaluation of cognitive, behavioral, and emotional functioning) testing suggested R1 has Diffuse Lewy Body Disease (a progressive neurodegenerative disorder characterized by cognitive decline, severe, fluctuations in alertness and detailed visual hallucinations).</p> <p>R1's quarterly Minimum Data Set (MDS) dated 3/13/26, identified R1 had moderate cognitive impairment, had delusions/hallucinations, no other behaviors, no rejection of care, no wandering, did not use a walker or wheelchair, was independent with transfer and ambulation, had two or more falls</p>	F0689	<p>Continued from page 1 approach to safety that is individualized, review assessments and observations to identify any specific hazards in the environment including adequate supervision, implementing interventions and monitoring the effectiveness of the interventions. Clinical staff were also in-serviced that if a resident refuses to wear the wander guard, the staff will be responsible for implementing alternative interventions such as, 1:1, initiating 15-min checks or contacting local authorities. These interventions must be care planned and family and MD notification will be documented.</p> <p>Director of Nursing is responsible for compliance.</p> <p>Audits on elopement assessment completion, care plan initiation and interventions will begin weekly x 3 weeks then monthly to ensure compliance.</p> <p>Audit results will be reviewed by the Administrator, and the Administrator will take audit results to QAPI for review and recommendation.</p> <p>Compliance: 05/12/2026</p>	05/12/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 04/20/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER Valley View Manor Hcc</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152</p>		
(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
<p>F0689 SS = SQC-J</p>	<p>Continued from page 2 since admission with no injury, and used a wander/elopement alarm daily (Per Elopement Evaluation the device was not applied until 3/26/26).</p> <p>Review of R1's record identified hourly safety checks were initiated on 3/23/26, however the record did not include a corresponding comprehensive assessment that had determined the frequency safety checks were appropriate and individualized to R1's risks and safety needs.</p> <p>R1's elopement evaluation dated 3/26/26, identified R1 was at risk for elopement due to wandering behaviors that were likely to affect the safety or wellbeing of self/others. Wanderguard was applied.</p> <p>R1's March 2026 Medication Administration Record (MAR) included a physician order dated 3/28/26 to check Wanderguard (name brand for a personal safety device) function and placement every shift for elopement/wandering.</p> <p>Review of R1's care plan 3/26/26 through 4/13/26, did not identify an elopement focus care plan had been developed and implemented with interventions to prevent R1 from leaving the facility unsupervised.</p> <p>R1's progress note dated 3/28/26 at 5:40 a.m., R1 was up early parts of the shift wandering in hallways and finally laid down at 3:30 a.m. but was not sleeping. R1 took off bracelet (Wanderguard) from hand and bracelet replaced on right ankle.</p> <p>R1's progress note dated 3/28/26 at 10:48 p.m., R1 would not allow staff to check for bracelet on leg properly.</p> <p>R1's progress note dated 3/29/26 at 4:39 a.m., R1 was up early hours of the night and laid in bed around 1:30 a.m. R1 would not allow staff to touch ankles to check for bracelets.</p> <p>R1's progress note dated 3/29/26 at 10:59 a.m., R1 had cut off her alarm bracelet on the night shift and was found in the garbage can.</p> <p>R1's progress note dated 3/29/26 at 4:14 p.m., R1 took Wanderguard off and will not allow replacement.</p> <p>R1's progress note dated 3/29/26 at 8:51 p.m., identified R1 had cut off Wanderguard with a scissor at some point during the night last night and was found in her room and was found in the garbage and then placed in the medication cart.</p>	<p>F0689</p>		<p>05/12/2026</p>

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 04/20/2026	
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
F0689 SS = SQC-J	<p>Continued from page 3</p> <p>During an interview on 4/15/26 at 4:25 p.m., director of nursing (DON) stated R1 had an elopement evaluation completed on 3/26/26 because R1 had started to make exit seeking comments; based on the evaluation it was determined R1 was at risk for elopement and had a Wanderguard placed on 3/26/26 as an intervention to reduce the risk for elopement. However, R1 removed her Wanderguard on 3/28/26 and again on 3/29/26 and would not allow staff to reapply a new one. DON explained R1 had been on hourly checks since 3/23/26 but had not had any increase in supervision and/or alternate interventions to reduce the risk of R1 eloping after R1 removed her Wanderguard. DON further explained R1 did not have an elopement focus care plan that informed staff of R1's elopement risk and interventions until 4/15/26.</p> <p>R1's progress note dated 3/31/26 at 6:37 a.m., identified R1 no longer had Wandergaurd on.</p> <p>R1's progress note dated 3/31/26 at 3:11 p.m., identified "R1 does not wear [Wanderguard]."</p> <p>R1's progress note dated 3/31/26 at 10:57 p.m., identified R1 did not have a Wandergaurd and refused to apply during room checks.</p> <p>R1's progress note dated 4/1/26 at 7:29 a.m., identified R1 refused to wear [Wanderguard].</p> <p>R1's progress note dated 4/1/26 at 5:43 p.m., identified R1 approached writer and asked, "Are you going to leave me too." R1 then said, "I want to get out of here for a couple weeks and they will not let me." Writer explained to R1 that she could go on a leave of absence with a responsible party. R1 stated, "Yeah right, they will not let me go and go to hell."</p> <p>During an interview on 4/16/26 at 11:44 a.m., social service designee (SSD) stated she did not feel R1's comments on 4/1/26 were exit seeking in nature, however, SSD was not aware that R1 had been determined an elopement risk on 3/26/26 and if she had been aware of this she would have considered this exit seeking comments and R1 should have had additional interventions put in place.</p> <p>R1's progress note dated 4/4/26 at 2:06 p.m., identified R1 was confused and following nurse around the facility. R1 was talking about people disappearing and when she opens her mouth and talks, she gets herself in trouble. R1 wandered around the facility all day and went outside with other residents but did not attempt to leave the facility.</p>	F0689		05/12/2026

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 4</p> <p>R1's progress note dated 4/7/26 at 3:01 p.m., identified R1 was confused this morning, walking around facility, following nursing staff seeking reassurance. R1 seemed very nervous, with her bottom lip quivering. R1 mentioned she needed to get her taxes done and she thought the writer was going to do them for her. Writer told R1 she could not do her taxes, then R1 approached writer shortly after with similar concerns. Staff called R1's power of attorney (POA) to talk to R1 to let her know POA would take care of her taxes. R1 then expressed concerns about where she was going to live and told R1 she could remain at the facility.</p> <p>R1's progress note dated 4/9/26 at 4:43 a.m., identified R1 stood outside of door and stated her toilet smelled. No odor noted from toilet, but staff flushed toilet to "content her."</p> <p>R1's progress note dated 4/10/26 at 1:17 p.m., identified R1 informed staff that she had "groundhogs" in her room. Staff told R1 there was no groundhogs in her room. R1 then got very close to staff members face and stated, "If you don't get those groundhogs out of my room, I'm going to slit your throat." Suggested to social services that R1 be moved to the front of the facility where she can be around more people and easier seen by staff.</p> <p>R1's progress note dated 4/10/26 at 3:00 p.m., identified R1 had a room change.</p> <p>R1's progress note dated 4/10/26 at 9:53 p.m., identified R1 spent a lot of shift by the nursing station due to being upset that she had a room change. R1 was offered food, but intervention was ineffective.</p> <p>In review of R1's record between 3/26/26 through 4/13/26 it was not evident R1's Wanderguard was reapplied, not evident the care plan interventions were re-evaluated for effectiveness nor evident a comprehensive assessment completed to determine individualized interventions including the appropriate level of supervision frequency after R1 had continued wandering and exit seeking without a Wanderguard in place.</p> <p>R1's Hourly Safety checklist reviewed from 4/3/26 through 4/13/26, was not completed. The checklist identified no safety checks documented for the following days/times:</p> <p>-4/3/26 through 4/5/26: No safety checks completed.</p>	F0689		05/12/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 04/20/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER Valley View Manor Hcc</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152</p>		
(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
<p>F0689 SS = SQC-J</p>	<p>Continued from page 5</p> <p>-4/6/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.</p> <p>-4/7/26: 1:00 a.m. through 5:00 a.m.; 3:00 p.m. through 11:00 p.m.</p> <p>-4/8/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.</p> <p>-4/9/26: 1:00 a.m. through 5:00 a.m.; 3:00 p.m. through 11:00 p.m.</p> <p>-4/10/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.</p> <p>-4/11/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.</p> <p>-4/12/26: 1:00 a.m. through 5:00 a.m.; 10:00 p.m. or 11:00 p.m.</p> <p>-4/13/26: No documentation of any hourly safety checks</p> <p>R1's elopement incident report dated 4/13/26, identified R1 had been brought a sandwich at 4:55 a.m., when brought R1 pudding to her room at 5:03 a.m., R1 was not in her room. Staff searched the facility and grounds, called management, and found R1 at 5:28 a.m. R1 refused to return to the facility and was sent to emergency department with law enforcement.</p> <p>According to the weather station in Hansen-Tracy Weather Station (KMNTRACY12) the temperature on 4/13/26 at 5:04 a.m., had an actual temperature of 51.4 degrees.</p> <p>R1's emergency department (ED) note dated 4/13/26, identified R1 had been brought to the ED after going missing at the nursing home around 5:00 a.m. and was later found in the street wandering and became combative. R1 had stated she wanted to harm herself by jumping in front of a car. R1 was orientated to name and date of birth but required orientation to place. Not oriented to date or situation. R1 stated she would never actually hurt herself. R1 was unable to provide coherent history regarding events that occurred. R1 stated she had heard and seeing things before that were not there but was unable to provide further information regarding this. R1 had a history of Lewy Body Dementia and communication with R1's behavioral health provider recommended R1 be admitted to a geriatric psychology facility for re-evaluation and</p>	<p>F0689</p>		<p>05/12/2026</p>

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 6 stabilization.</p> <p>During an interview on 4/15/26 at 12:58 p.m., nursing assistant (NA)-F stated R1 had a Wanderguard put on her a few weeks prior to her elopement and was told she had removed her own bracelet on 3/29/26 and refused to have another bracelet applied. NA-F stated they were not doing any additional interventions to mitigate the risk of R1 eloping such as increase in supervision especially since she had cut off her wander bracelet. NA-F explained R1 would always wander in the hallways through the day but was unsure if she had attempted to leave the facility prior to leaving on 4/13/26, however, R1 would make comments that she wanted to leave the facility at times. NA-F stated R1 had behavior changes in the past week prior to her eloping such as hiding around corners and watching staff closely and just acting differently. NA-F explained she had been instructed to read a handout on elopement that was at the nursing station but had not had time to read it yet. NA-F could not articulate where to locate how to identify if a resident was at risk for elopement but would reference the care plan/Kardex to help her identify which resident was at risk.</p> <p>During a phone interview on 4/16/26 at 6:38 a.m., licensed practical nurse (LPN)-A stated R1 had been moved to a different part of the building on 4/10/26 due to her hallucinating in her old room. R1 had been seeing groundhogs in her room and by moving R1 the facility thought it might help with her hallucinations. LPN-A explained she was the night nurse on 4/13/26 and R1 had been wandering in the hallways and had been given a snack around 4:30 a.m. then R1 went back to her room. LPN-A stated at around 4:55 a.m., R1 had returned to the nursing station to ask for something to eat. LPN-A then offered to get R1 some pudding and then R1 began to walk down the hallway in the opposite direction of her room, LPN-A then redirected R1 to the direction of her room and told R1 she would bring her the pudding to her room. LPN-A did not make sure R1 went to her room, she went to the kitchen to get ice water and pudding for R1 while NA-A went to go and answer a call light for another resident. LPN-A then went to R1's room around 5:03 a.m. and noticed R1 was not in her room. LPN-A then immediately had NA-A and NA-B begin to search for the facility for R1, but they were unable to locate R1. LPN-A then called 911 and had NA-A go outside to search around the building for R1. When NA-A could not locate R1 she had NA -B take her car to begin driving around the town for R1. LPN-A stated it was still dark out and the weather was foggy that</p>	F0689		05/12/2026

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 7 morning. LPN-A stated NA-B had called her around 5:30 a.m., to say she had found R1 about 5-6 blocks away on the street and that R1 refused to return to the facility with her. LPN-A then sent NA-A to drive to the location of NA-B to assist. LPN-A explained neither NA-A nor NA-B could get R1 to return; R1 had become combative and began striking out at staff. LPN-A then sent other staff to attempt to get R1 to return to the facility.</p> <p>During an interview on 4/15/26 at 3:22 p.m., NA-A stated he was aware R1 had removed her Wanderguard bracelet on 3/29/26 and had refused to allow another bracelet to be applied, however, R1 had been on hourly checks since 3/23/26, but had not been doing the checks consistently during his shifts and would but he normally just kept a "close eye" on R1. NA-A was unaware of any other elopement intervention in place for R1 to prevent her from eloping. NA-A stated he worked the night shift on the day that R1 eloped from the facility. R1 had been awake that night and came to the nursing station around 4:30 a.m., asking for something to eat. Licensed practical nurse (LPN)-A had given R1 a sandwich and then R1 returned to her room. At around 4:55 a.m., R1 came back to the nursing station and asked for something else to eat at which time, LPN-A asked R1 if she would like some pudding. R1 did not respond but shrugged her shoulder and began walking in the opposite direction of her room, at which time LPN-A directed R1 in the opposite direction towards R1's room. As R1 was walking in the direction of her room, LPN-A headed towards the kitchen to get ice water for another resident and pudding. NA-A answered another resident's call light before R1 was seen entering her room. When NA-A completed answering the other resident's call light he was notified by LPN-A that R1 was missing, and he began to search the building to see if R1 could be located. NA-A then searched all the room and then began looking outside around the building but could not locate R1. LPN-A had given instructions to NA-B to get in her car and begin to search the town for R1. NA-B called NA-A at around 5:30 a.m., to inform him she had located R1 but needed additional assistance because R1 refused to go with NA-B. NA-A then got in his car and went to the location where R1 and NA-B were at which was about 5-6 blocks away. R1 had shoes and a zip up hoodie when he got to her and still refused to go with either NA-A and NA-B and began to strike out at NA-A. NA-B and NA-A remained close by R1 and continued to try and convince R1 to come with them back to the facility, but R1 continued to refuse. At around 5:45 a.m., LPN-B arrived and attempted to get R1 to</p>	F0689		05/12/2026

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 8 return to the facility but R1 continued to refuse. LPN-B then directed NA-A and NA-B back to the facility.</p> <p>During an interview on 4/15/26 at 3:01 p.m., NA-B was aware R1 had a Wanderguard placed, however, R1 had removed it and did not allow staff to replace it. R1 wandered around the facility at night and would sit at the nursing station to visit with staff. R1's cognition had been getting worse; she had been seeing things like groundhogs so on 4/10/26 she was moved to a different room to see if that would help. NA-B was unaware if R1 was on hourly checks and had not been documenting any hourly checks. NA-B stated she was working the night shift on 4/13/26 when R1 eloped from the facility. NA-B had received a call on the walkie talkie around 5:00 a.m. from LPN-A giving her direction to search the facility for R1 because she was missing from her room. NA-B searched her wing and could not locate R1. About 5:10 a.m., she was told by licensed practical nurse (LPN)-A to get in her car and drive around town to see if she could locate R1. NA-B stated it was dark and foggy outside when she got in her car and began driving slowly around town. Around 5:30 a.m., she found R1 walking about five or six blocks from the facility. NA-B had attempted to get R1 to return to the facility with her but R1 refused, so NA-B called the nursing home and asked for another staff member to assist her. R1 continued to walk toward the main street and continued to refuse to come back to the facility.</p> <p>During an interview on 4/16/26 at 11:44 a.m., social services designee (SSD) stated the facility had moved R1 on 4/10/26 to a different room on a wing closer to the nursing station to "keep a better eye on R1" because her cognition had begun to decline and she had been having more hallucinations in her previous room. The move had not been based on her elopement risk; nursing had been attempting to get R1 to move to her current location by the nursing station for some time. SSD stated she had been contacted on 4/13/26 around 5:34 a.m., SSD was informed R1 had eloped from the facility. SSD walked to the location where staff were at with R1. SSD stated she remained with R1 who had continued to refuse to come with staff back to the facility. SSD stated R1 had continued to walk across a railroad track and stated, "she wanted to just walk in front of train and "end it all". SSD explained she remained walking with R1 who then walked across a busy highway and finally sat on a bench in front of the gas station when the local police arrived and took R1 to the ED.</p>	F0689		05/12/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 04/20/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER Valley View Manor Hcc</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152</p>		
(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
<p>F0689 SS = SQC-J</p>	<p>Continued from page 9 During a phone interview on 4/16/26 at 2:42 p.m., medical director (MD) stated any resident identified at risk for wandering/elopement should have appropriate interventions in place to mitigate the risk of the resident eloping. MD explained by R1 being allowed to elope on 4/13/26 this put her at risk for serious harm, injury, or even death. During a follow up phone interview on 4/16/26 at 4:26 p.m., MD explained R1 had worsening cognition due to her Lewy Body Dementia and was not able to make safe decisions and this was why she was in the nursing home in the first place.</p> <p>During an interview on 4/15/26 at 4:25 p.m., DON explained that after R1 had eloped they had completed a re-assessment of all residents on 4/14/26 for elopement risk, reviewed/revised care plans, and provided began providing education to the nursing staff on elopement and what to do if a resident elopes, but did not provide any education on what to do if a resident removes a Wanderguard.</p> <p>Although the DON reported after R1 eloped on 4/13/26, all residents were re-assessed for elopement risk, care plans were reviewed/revised, and staff were educated, the facility failed to ensure the identified elopement risks for R4 and R6 were incorporated into individualized care plan interventions that were implemented, and clearly communicated to staff, and failed to ensure consistent monitoring. -</p> <p>R4's face sheet dated 4/20/26, identified diagnoses of dementia,</p> <p>R4's quarterly MDS dated 3/28/26, indicated R4 had moderate cognitive impairment, physical and verbal behaviors that occurred one to three days, no rejection of care, had no impairment on upper extremities, used a wheelchair, was dependent with wheelchair mobility, had no wandering, had falls since admission, and did not use a wander/elopement alarm.</p> <p>R4's Elopement/Wandering focus care plan dated 12/19/24, identified R4 was low risk for Wandering/Elopement.</p> <p>-Identify if there are triggers for wandering/eloping. (dated 12/20/24)</p> <p>R4's progress note dated 3/5/26 at 10:05 a.m., identified R4's call light was on, however R4 was headed towards the lobby and the nursing station. R4 stated he wanted to get in the recliner, staff told</p>	<p>F0689</p>		<p>05/12/2026</p>

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 10 him they needed to get a second person for assistance. R4 stated he wanted to "get out of the f---ing place."</p> <p>R4's progress note dated 3/22/26, identified R4 became upset when his wife went home and stated, "he is stuck here, and she gets to leave."</p> <p>R4's Elopement Evaluation dated 3/27/26, identified R4 was at risk for elopement due to verbally expressing desire to go home, pack belongings or stayed near the exit door.</p> <p>R4's Elopement Evaluation dated 4/14/26, identified R4 was at risk for elopement due to verbally expressing desire to go home, pack belongings or stayed near the exit door. R4's care plan did not include individualized care plan with interventions to mitigate the risk of elopement.</p> <p>During an interview on 4/16/26 at 9:22 a.m., LPN-B stated R4 gets upset at times that he cannot leave the facility when his wife leaves after visiting and makes exit seeking comments after she leaves. LPN-B stated she was not aware if R4 had been determined an elopement risk, however, LPN-B stated R4 was able to propel himself in his wheelchair throughout the facility at times and could easily attempt to leave the facility unaccompanied.</p> <p>During an observation on 4/16/26 at 9:45 a.m., R4 was seated in his wheelchair in the day room and was seen propelling himself in his wheelchair around the room.</p> <p>During interview on 4/16/26 at 12:39 p.m., NA-D stated that she referred to a resident's care plan/ Kardex to identify if a resident who wanders and if they were at risk for elopement and what interventions were in place. NA-D stated R4 could wheel himself in his wheelchair and could push the handicap button and get out the door if he wanted to. NA-D stated R4 would get upset and state he wanted to go home with his wife visited and left the building. NA-D stated staff redirected R4 and reminded him why he could not go home with his wife. NA-D stated R4's mood was better, since R4 was more used to staff. NA-D reviewed R4's Kardex and confirmed the Kardex did not identify R4 as an elopement risk, no triggers, nor a listing of interventions to mitigate elopement.</p> <p>During an interview on 4/16/26 at 1:25 p.m., assistant director of nursing (ADON) stated R4 had been identified as a risk for elopement, however, ADON believed R4 would not be strong enough to</p>	F0689		05/12/2026

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 11 propel himself in his wheelchair to get himself outside and did not have any additional interventions like a Wanderguard applied to alert staff if he attempted to leave.</p> <p>R6</p> <p>R6's face sheet dated 4/20/26, identified diagnoses of dementia, Parkinson's disease, and diabetes.</p> <p>R6's admission MDS dated 4/6/26, identified R6 had moderate cognitive impairment, no behaviors, no rejection of cares, no wandering, used a walker, was independent with transfers, independent with ambulation, and did not use a wheelchair.</p> <p>R6's Elopement Evaluation dated 3/31/26, identified R6 was at risk for elopement due to a history of elopement or an attempted elopement while in home; R6 had been admitted within the past 30 days and is not accepting the situation. Intervention selected to engage in purposeful activity.</p> <p>R6's Wandering/Elopement care plan dated 3/31/26, identified R6 was at risk for wandering/elopement. Goal to not leave the facility unattended with a corresponding intervention directing staff to engage resident in purposeful activity.</p> <p>R6's progress note dated 3/31/26, identified R6 had poor safety awareness on admission.</p> <p>R6's progress note dated 3/31/26, identified R6 as an elopement risk and utilized wander elopement alarm. Review of R6's record revealed no indication of Wanderguard placement until 4/15/26.</p> <p>R6's progress note dated 4/1/26, identified a resident preference evaluation completed. R6 identified it was very important to him to go outside to get fresh air when the weather is good.</p> <p>R6's progress note dated 4/1/26 at 4:30 a.m., identified R6 was up one time during shift and asking for a snack and then ambulated to the south side of the building to "stretch his legs a little."</p> <p>R6's Elopement Evaluation dated 4/14/26, identified R6 was at risk for elopement due to verbally expressed the desire to go home, packed belongings to go home, or stayed near the exit door, recently admitted to the facility within the past 30 days and is not accepting the situation. Intervention selected to engage in purposeful activity and monitor location frequently. R6's elopement evaluation did</p>	F0689		05/12/2026

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 12 not identify history of elopement that was identified in R6's 3/31/26 elopement evaluation. R6's care plan did not identify any revisions to his care plan to mitigate the risk of elopement.</p> <p>R6's progress note dated 4/14/26 at 6:18 p.m., identified R6 stated he had a home to go to/live in. Wanderguard attempted to be placed on 4/14/26, however, R6 refused. Will attempt to place Wanderguard again on 4/15/26. R6's record did not identify any additional elopement prevention interventions to R6's care plan since R6 refused to have a Wanderguard be applied.</p> <p>R6's progress note dated 4/15/26 at 10:00p.m., identified a Wanderguard placed on R6's left wrist.</p> <p>R6's wandering/elopement care plan revised on 4/15/26 to include the following:</p> <ul style="list-style-type: none"> -Identify wandering/elopement de-escalation behaviors, Wanderguard placed on 4.15.26. -Identify if there are triggers for wandering/elopeing -R6 does have Wanderguard in place. <p>During an interview on 4/16/26 at 9:22 a.m., LPN-B stated R6 has wandered throughout the facility since admission and also made exit seeking comments about wanting to go home to get his "back brace". LPN-B explained she was not made aware R1 was an elopement risk until she was asked to place a Wanderguard on R6 on 4/15/26. LPN-B further explained R6 could have easily eloped from the facility prior to 4/15/26 because he was independent in the facility with only his walker and staff may not have seen him leave.</p> <p>During interview on 4/16/26 at 12:39 p.m., NA-D stated R6 was admitted to the facility a few weeks ago and would wander in the hallways independently with a walker. NA-D explained R6 made comments about wanting to go home at times. NA-D reviewed R6's Kardex and was unsure of R6's triggers for Wandering and/or elopement.</p> <p>During an interview on 4/16/26 at 1:01 p.m., ADON stated R6 was identified as an elopement risk on admission because R6 had eloped from a previous facility. ADON explained she determined R6 should have a Wanderguard bracelet placed on admission, however, the facility did not have any Wanderguard bracelets at the time of admission that were not expired, and the facility was unable to place a bracelet on R6. ADON further explained the facility</p>	F0689		05/12/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245378</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 04/20/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER Valley View Manor Hcc</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST NINTH AVENUE , LAMBERTON, Minnesota, 56152</p>		
(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
<p>F0689 SS = SQC-J</p>	<p>Continued from page 13 had not put any additional interventions in place to prevent R6 attempting to leave the facility unsupervised and should have put things in place prior to placing the Wanderguard on 4/15/26.</p> <p>During an interview on 4/16/26 at 12:46 p.m., NA-C stated she was aware R1 was an elopement risk but did not identify R4 nor R6 as an elopement risk and was unsure of any interventions to mitigate the risk of R4 or R6 from leaving the facility unattended. NA-C stated Wanderguards were a replacement for resident supervision and if a resident had a wander bracelet they would not need to be supervised as much.</p> <p>Review of the facility's Safety and Supervision of Resident's Policy undated, identified the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities.</p> <p>Individualized, Resident-Centered Approach to Safety</p> <p>-Our individualized, resident-centered approach to safety addresses safety and accident hazards for individualized residents.</p> <p>-The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individualized residents.</p> <p>-The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.</p> <p>-Implementing interventions to reduce accident risks and hazards shall include the following: Communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions; providing training as necessary; ensuring that interventions are implemented; documenting interventions.</p> <p>-Monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently; evaluating the effectiveness of interventions; modifying or replacing interventions as needed; evaluating the effectiveness of new or revised interventions.</p>	<p>F0689</p>		<p>05/12/2026</p>

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 04/20/2026
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
F0689 SS = SQC-J	<p>Continued from page 14</p> <p>Review of the facility's Wander Management Policy dated 6/24/22, identified a wander management alarm system may be used on a resident who is deemed unsafe through the nursing assessment and documented on the resident's care plan that the resident is at risk for elopement.</p> <p>PROCEDURE</p> <ul style="list-style-type: none"> -A nursing assessment of each resident must be done per established frequency risk for elopement. -A plan of care must be formulated with the Interdisciplinary Team (Nursing, Physical Therapy, Occupational Therapy, Dietary, Activities, Social Worker, and Resident/Family), to determine the need for the wander guard bracelet and this information will be documented in the resident care plan. -The wander management system bracelet will be applied to the resident's dominant wrist (per manufacturer instruction). The wander management bracelet should not be removed until replacement is needed and/or the resident is discharged from the unit or facility. The wander management bracelet expiration date and model # (if available) should be documented in the resident wander management physician order and care plan. -After applying the wander management system bracelet, a safety check to make sure the bracelet fit is appropriate per manufacturer instructions. This safety check must be completed and documented in the resident medical record before leaving the resident. -The wander management system bracelets are checked every shift for placement and weekly for function. <p>The IJ was removed 4/17/26, when it was verified, the facility completed the following:</p> <ul style="list-style-type: none"> -The Elopement and Safety/Supervision of Resident Policy and Procedure was reviewed with no revisions warranted. -All current residents were reassessed for elopement risk and care plan interventions put in place to mitigate the risk for elopement. -R4 was placed on 15-minute checks and then had a wanderguard placed. -R6 had a wanderguard applied. 	F0689		05/12/2026

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 04/20/2026
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
F0689 SS = SQC-J	Continued from page 15 -R4 and R6 had resident centered interventions added to their care plan if they attempt to exit seek. -Facility nursing staff were in-serviced on the Safety/Supervision of Resident Policy prior to the beginning of their shift.	F0689		05/12/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements	F0656	R1 has since been discharged from the facility. All current residents' care plans were reviewed for risks and updated as needed. Future residents who admit their care plans will be initiated for risks per facility policy. Licensed nurses will be in-serviced on the Comprehensive Care Plan with focus on initiating measurable objectives to meet the resident's physical, psychosocial and function needs. The resident comprehensive care will also incorporate identified risk problem areas. Director of Nursing is responsible for compliance. Audits on comprehensive care plan initiation for risk areas (pressure injuries, falls, elopement, smoking), goals and interventions will begin weekly x3 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: 05/12/2026	05/12/2026

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 04/20/2026	
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
F0656 SS = D	<p>Continued from page 16 set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interview and document review the facility failed to develop a comprehensive person-centered Elopement care plan that included interventions to mitigate the risk of elopement for 1 of 1 resident (R1) reviewed for accidents.</p> <p>Findings include:</p> <p>R1's face sheet dated 4/15/26, identified diagnoses of unspecified dementia without behavioral disturbance and depression.</p> <p>R1's Quarterly Minimum Date Set (MDS) dated 3/13/26, identified R1 had moderate cognitive impairment, had delusions/hallucinations, no other behaviors, no rejection of care, no wandering, did not use a walker or wheelchair, was independent with transfer and ambulation, had two or more falls since admission with no injury, and used a wander/elopement alarm daily.</p> <p>R1's elopement evaluation dated 3/26/26, identified R1 was at risk for elopement due to wandering behaviors that were likely to affect the safety or wellbeing of others. R1 had a personal safety device applied.</p> <p>During an interview on 4/15/26 at 4:25 p.m., director of nursing (DON) stated R1 had an elopement evaluation completed on 3/26/26 due to R1 making exit seeking comments and was determined to be at risk for elopement and had a wanderguard (name brand for a personal safety device) placed as an intervention. DON explained R1 had not used a wanderguard prior to that date.</p> <p>Review of R1's care plan 3/26/26 through 4/13/26, did not identify an elopement focus care plan had been initiated with interventions to prevent R1 from leaving the facility unsupervised.</p> <p>R1's elopement incident report dated 4/13/26, identified R1 had been brought a sandwich at 4:55 a.m., when brought R1 pudding to her room at 5:03 a.m., R1 was not in her room. Staff searched the facility and grounds, called management, and found</p>	F0656		05/12/2026

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 04/20/2026
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
F0656 SS = D	<p>Continued from page 17 R1 at 5:28 a.m. R1 refused to return to the facility.</p> <p>R1's record identified R1's care plan for elopement was not developed and initiated until 4/15/26 which included R1 was at risk for wandering/elopement. Goal that R1 will not leave facility unattended. Interventions dated 4/15/26 as follows:</p> <ul style="list-style-type: none"> -Clearly identify resident's room and bathroom. -Identify if there are triggers for wandering/elopeing. R1 is suspected to have Lewy Body type dementia; provide R1 with medications as ordered. -Identify if there is a certain time of day wandering/elopement attempts to occur. -Identify if there is a certain time of day wandering/elopement attempts occur. -Identify wandering/elopement de-escalation behaviors. -Provide care in calm and reassuring manner. -Provide clear and simple instruction. <p>During an interview on 4/15/26 at 12:58 p.m., nursing assistant (NA)-F stated R1 had a wanderguard put on her a few weeks prior to her elopement and was told she had removed her own bracelet on 3/29/26 and refused to have another bracelet applied. NA-F stated she was not aware if R's care plan had any increased supervision since she had cut off her bracelet nor any other interventions in place to prevent her from eloping. NA-F explained R1 would always wander in the hallways through the day but was unsure if she had attempted to leave the facility prior to leaving on 4/13/26, however, R1 would make comments that she wanted to leave the facility at times.</p> <p>During an interview on 4/16/26 at 4:42 p.m., director of nursing (DON) stated R1 should have had a wandering/elopement care plan initiated on 3/26/26 when the elopement assessment had been completed to inform staff of needed interventions to mitigate the risk of R1 eloping, however, R1 elopement care plan was not initiated until 4/15/25 after R1 had eloped on 4/13/26.</p> <p>Review of the facility's Care Plans, Comprehensive Person-Centered Policy undated, identified a comprehensive, person-centered care plan that includes measurable objectives and timetables to</p>	F0656		05/12/2026

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 04/20/2026	
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
F0656 SS = D	<p>Continued from page 18 meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>The comprehensive, person-centered care plan will:</p> <ul style="list-style-type: none"> -Include measurable objectives and timeframes. -Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. - Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. -Describe any specialized services to be provided as a result of PASARR recommendations. -Include the resident's stated goals upon admission and desired outcomes. -Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire. -Incorporate identified problem areas. -Incorporate risk factors associated with identified problems. -Build on the residents' strengths. -Reflect the resident's expressed wishes regarding care and treatment goals. -Reflect treatment goals, timetables, and objectives in measurable outcomes. -Identify the professional services that are responsible for each element of care. -Aid in preventing or reducing decline in the resident's functional status and/or functional levels. -Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and -Reflect currently recognized standards of practice for problem areas and conditions. <p>Care plan interventions are chosen only after careful</p>	F0656		05/12/2026

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 04/20/2026
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
F0656 SS = D	Continued from page 19 data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. -When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. -Care planning individual symptoms in isolation may have little, if any, benefit for the residents.	F0656		05/12/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/20/2026
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
20000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS:</p> <p>On 4/15/26, 4/16/26, 4/20/26 a standard abbreviated survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p> <p>The following complaints were</p>	20000		05/12/2026

Office of Primary Care and Health Systems Management

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

