STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245378	A. Building B. Wing	07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Manor Hcc	200 East Ninth Avenue Lamberton, MN 56152

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and document review the facility failed to ensure they had obtained and documented an informed consent, including an explanation of the risks and benefits of using a psychotropic medication or alternative treatment options for 1 of 5 residents (R4) sampled. Findings include: R4's Minimum Data Set (MDS) assessment, accepted on 7/2/26, identified his cognition was mildly impaired, he was dependent on staff to complete activities of daily living (ADL)'s, and had diagnoses of dementia, traumatic brain injury, anxiety, and depression. R4 reported feeling down, depressed, or hopeless several days during the look-back period. R4's Medication Administration Record identified the facility was administering escitalopram (an antidepressant) 5 milligrams (MG) daily for generalized anxiety starting on 12/30/25 and quetiapine (an antipsychotic) 100 mg at bedtime for unspecified dementia with agitation starting on 12/4/25. Interview and document review on 7/8/26 at 8:55 a.m., with the assistant director of nursing identified she was unable to find documentation in R8's medical record that a consent had been obtained, or that risks and benefits or alternative treatment options had been provided to R4 or their resident representative. Review of the facilities Antipsychotic Medication Use policy identified the facility would ensure residents only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician was to, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. Residents who were admitted from the community or transferred from a hospital and who were already receiving antipsychotic medications were to be evaluated for the appropriateness and indications for use. In addition, the hospital, previous nursing home or assisted living resident record was to include the physician diagnosis, indication for use and include documentation that the resident acknowledged consent to receive prescribed psychotropic medications. Prior to starting a new psychotropic medication, the physician was to document the resident/resident representative consent in their progress notes. Medication monitoring and documentation was to include checking for side effects at least daily for the first six weeks after a resident began taking a new psychotropic medication, or a significant increase or decreased dose occurred of a currently used psychotropic medication, and at least quarterly thereafter. Minor increases or decreases in the dose of a currently used psychotropic medication did not require to be monitored as frequently as a new medication or a significant increase or decrease of a currently used psychotropic medication. In addition to appropriate physical or laboratory assessments as determined by the medically licensed person, standardized checklists or rating scales, or scales developed for a specific drug or drug class, were to be used as monitoring tools.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and document review the facility failed to ensure a gradual dose reduction (GDR) was attempted, or a rationale was provided for 1 of 5 residents (R4) sampled. Findings include: R4's Minimum Data Set (MDS) assessment accepted on 7/2/26, identified his cognition was mildly impaired, he was dependent on staff to complete activities of daily living (ADL)'s and had diagnosis of dementia, traumatic brain injury, anxiety, and depression. R4 reported feeling down, depressed, or hopeless several days over past 2 weeks. R4 had no behaviors during the assessment period. Antipsychotics were received on a routine basis and a gradual dose reduction was noted to have not been attempted. R4's Medication Administration Record identified the facility was administering escitalopram (an antidepressant) 5 milligrams (MG) daily for generalized anxiety and quetiapine (an antipsychotic) 100mg at bedtime for unspecified dementia with agitation. R4's November 2025, pharmacy (RPh) medication review report identified a recommendation to the physician (MD) by the RPH to assess R4 for continued use of escitalopram and quetiapine. If the current dose is still appropriate for the patient, the RPh asked the MD to please provide the clinical rationale for continuing the current dose. The physician reviewed and accepted the report. The physician replied for R4 to continue with medication, and she would evaluate on the next nursing home rounds. His mood was noted to be stable. R4's 12/4/25, nurse practitioner (NP)-A's progress note, (completed after nursing home rounds) identified the pharmacy review was completed on 11/25/25. The quetiapine was started on 9/5/24, and the escitalopram was started on 3/28/25. NP-A noted to be questioning if the current dosing on the medications was still appropriate. A response was given to the RPh to continue as is and will continue to monitor on routine rounds, sooner if there are acute concerns. R4's mood continued to be stable. Vitals were reviewed. No changes were recommended. Interview and document review on 7/8/26 at 8:55 a.m., with the assistant director of nursing (ADON) identified she searched through R4's medical record and was unable to find documentation that a GDR had been completed or that rationale for not completing a GDR had been documented. Interview on 7/8/26 at 3:12 p.m., with the director of nursing (DON) identified that they typically will get a recommendation from the RPh alerting them when a resident was due for a GDR. They also have interdisciplinary team (IDT) meetings and behavior meetings where they talk about residents and their medication and if the IDT determines a GDR or any change in medications were needed, they notify the primary physician. The DON identified she agreed that documenting stable and was not an appropriate rationale for continued use. She discussed it with the rounding NP and determined they need to work on a better process to make the rationale clearer. She would expect the facility to follow policy and pharmacy recommendations and follow up with the physician to ensure pharmacy recommendations are acted upon. Review of the facilities current, undated Psychotropic Medication Use policy identified residents on psychotropic medications were to receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, in an effort to discontinue those medications. The policy identified the process would be completed by the IDT.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority (SMHA)) for 1 of 5 residents (R8) who had new on-set of mental illness. Findings include: R8's comprehensive Minimum Data Set (MDS) assessment accepted on 4/22/26, identified he had diagnoses of bi-polar disorder, PTSD, and personality disorder. R8's cognition was intact, and he had not displayed any behaviors during the assessment period. R8's Pre admission Screen (PAS) completed on 5/24/24, had a section noting if the person had a current diagnosis of mental illness to which it was documented he had a diagnosis of bi-polar disorder. There was no mention R8 had diagnoses of personality disorder or PTSD at that time. R8's diagnosis list identified he had been diagnosed with a personality disorder on 6/24/25 and PTSD on 5/28/24, both after his admission. Interview on 7/7/26 at 2:30 p.m., with the social service designee (SSD) identified she takes a glance at the PAS when they get a new admission to see if a level II PASARR is required but does not check for new diagnoses after admission, nor was she was aware the SMHA needed to be contacted to see if mental health services would be required. A policy was requested; however nothing was provided during the survey period.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure appropriate antibiotic use for 1 of 3 residents (R16), who were reviewed for antibiotic stewardship. Findings include: R16's 5/11/26, accepted discharge and entry Minimum Data Set (MDS) assessment identified she had severe cognitive impairment, required limited staff assistance with activities of daily living, (ADLs). She was frequently incontinent of both bowel and bladder and had diagnoses of diabetes, chronic kidney disease, and Alzheimer's disease. R16's 3/12/26 at 9:58 a.m. progress note identified the nurse practitioner (NP) had discussed the use of Macrobid (an antibiotic specifically used to treat acute, uncomplicated bladder infections (cystitis)), with R16's family member on 3/10/26 and would not recommend long-term use related to R16's age and the impact to her kidneys. R16's, 4/21/26 at 10:58 a m. NP note identified she was seen for a routine follow-up visit. The note reported she would not be ordering a chronic antibiotic for prevention of UTIs. She did provide a referral for R16 to be seen by urology if the family chose to do so, and documented R16 had only one UTI in the past 6-month period. R16's 5/4/26 at Urology consult visit note identified she was seen due to concerns with urinary incontinence, recurrent UTIs, and to be evaluated for UTIs. She had history of urinary incontinence, and difficulty with control of bladder function. The note identified UTIs were more frequent in the past and had been managed with daily antibiotics. It was noted since admission to the facility she had increased her fluid intake and reduced the frequency of UTIs. The assessment and plan identified UTIs had decreased in frequency, with recommendation for hydration and regular pad changes, to prevent infections. Recommendations were for Cranberry tablets BID, to consider the addition of vaginal estrogen cream; toilet Q2H when awake and increase water intake with a goal of 70 ounces per day. The note identified the patient's family member was going to obtain the Cranberry tablets. Urinary incontinence was reported as likely related to cognitive decline and medications. Risks and benefits of bladder medications were discussed, and a medication trial was deferred. Recommendation was to continue scheduled toileting every 2 hours and maintain adequate fluid intake. R16 and her family member voiced agreement with the discussed plan. R16's 5/17/26 at 4:39 p.m. physician visit note listed, I understand will she be able to come in to see me. I would love to give her antibiotics once a day to prevent a bladder infection. Let nursing home [facility] know Macrobid 100 mg q am q day . R16's 5/18/26 at 12:52 p.m. progress note identified R16 was hospitalized [DATE] through 5/11/26 with a principal diagnosis of Septic shock complicated secondary to acute cystitis (inflammation of the bladder) and complicated by Escherichia coli (a normal part of the gut flora, with the most common infection from a urinary tract infection(UTI), chronic kidney disease, acute kidney injury, acute cystitis with hematuria (blood in the urine), and gram-negative bacteremia (the presence of Gram-negative bacteria in the bloodstream). She was discharged back to the facility with an order for Ciprofloxacin (an antibiotic used to treat severe bacterial infections), 500 milligrams (mg) by mouth (PO) two times daily (BID) before meals, for four days. She also had an order for Cranberry 500mg BID for history of UTIs. She was to be toileted regularly and follow-up appointments were scheduled. R16's 5/21/26 physician order from physician (MD-A) identified Macrobid 100 milligrams (mg) (antibiotic) by mouth PO every (Q) morning (a.m.). No end date or date for reassessment of need for antibiotic was included. Interview on 7/8/26 at 9:08 a.m. with the infection preventionist (IP) reported the facility continued to have issues with medical staff completing antibiotic time outs and continuing to order antibiotics even if the criteria was not met. She identified R16 and had 6 months of no recurrent UTIs following admission. She had a history of recurrent UTIs when living in an assisted living situation, and it was thought the recurrent UTIs were likely a result of poor perineal hygiene after toileting. Her family wanted her to continue an antibiotic as a preventative measure even though she had no signs or symptoms. Education was provided by both nursing staff and the NP, but family continued to request orders for a prophylactic (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotic. R16 was also seen by Urology and education was provided to both the family and patient that antibiotic was not indicated related to the potential for kidney injury. The IP reported R16's family then contacted a different MD, who agreed to order a prophylactic antibiotic for the prevention of UTIs. She reported R16 was now experiencing increased peripheral edema felt to be a side effect of the ordered antibiotic. The MD was notified of the peripheral edema but continued to order the antibiotic, even though R16 had no signs or symptoms of a UTI, and there was no identified date to stop the antibiotic for evaluation of need. The IP reported the medical director was aware of the situation, but there was no resolution at the time of interview. Attempted interview with MD-A was made on 7/8/26 at 3:50 p.m. with a request for a return call. As return call was not received. Interview on 7/9/26 at 9:11 a.m., with the pharmacist (RPh) identified R16s medical record lacked documentation to justify prophylactic antibiotic use, and confirmed the order had an order date of 5/21/26, with no end date, nor a date for re assessment of need. She reported her expectation was for Antibiotic Stewardship criteria to be followed, and she had not addressed the issue in her June review but would request documentation for a risk verses benefit to be documented every 6 months. Interview on 7/8/26 at 4:30 p.m. with the director of nursing identified her expectation for antibiotic stewardship practices to be followed according to facility policy and the identified area of concern with R16 would need to be evaluated further. Review of the 10/4/21 Antibiotic Stewardship Policy identified a concentrated effort to decrease or eliminate unnecessary use of antibiotics for resident safety and to avoid unnecessary side effects. The seven identified elements of the Antibiotic Stewardship Program included: 1. Leadership Commitment 2. Accountability: Physician, nursing and pharmacy are responsible for promoting and overseeing antibiotic stewardship. 3. Drug Expertise: Identified by the consultant pharmacist. 4. Action: Implantation of policies and procedures for antibiotic use. 5. Tracking: Monitoring of antibiotic use with outcomes documented. 6. Reporting: Feedback to medical staff, nursing, and relevant staff on antibiotic use and any resistance to antibiotic stewardship practices. 7. Education: provision of antibiotic stewardship information to medical staff, nursing, residents and families on the need for antibiotic stewardship practices related to use of antibiotics. Prescribers were to base their treatment recommendations on likely UTI site, facility-specific culture with antibiotic sensitivity data, patient-specific data including age, prior antibiotic use, allergies, concomitant drug therapy, renal function and presence of a urinary catheter. The antibiotic stewardship team was directed to monitor the use of antibiotics, identify potential inappropriate use of an antibiotic for specific syndromes or prophylactic use to guide practice changes, and track any impact to residents.