Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 8, 2026

Administrator
River Valley Health And Rehabilitation Center LLC
200 SOUTH DEKALB STREET
REDWOOD FALLS, MN 56283

RE: CCN:245237
Cycle Start Date: March 24, 2026

Dear Administrator:

On March 24, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 24, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 24, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Health And Rehabilitation Center Llc	**200 SOUTH DEKALB STREET , REDWOOD FALLS, Minnesota, 56283**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 3/23/26-3/24/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/15/2026
F0000	INITIAL COMMENTS On 3/23/26-3/24/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52378861C (2665873), H52378862C (1058189), H52378863C (1058187 MN00112743), H52378865C (2598913). NO deficiencies were cited. The following complaint was reviewed: H52371662C (2696320), with deficiencies cited at F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		04/15/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F0580	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of	04/24/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0580 SS = D	Continued from page 1 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,	F0580	Continued from page 1 fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F580 Notify of Changes -The process for satisfying this requirement has been reviewed and revised as needed to ensure medical providers are notified of a residents' change in condition when getting sent to the emergency department. - Residents with a change in condition and sent to the emergency department have the potential to be affected if this requirement is not met. -R33's Provider has been notified of his visit to the ED. - All residents sent to the ER since 3/24 have been reviewed to ensure the provider was notified. -All licensed nurses will receive education on using the Monarch Healthcare Management change in condition policy to address similar situations. - Audits to monitor compliance and sustainability for provider notifications will be completed weekly for 4 weeks and monthly thereafter for 2 months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of the occurrence.	04/24/2026

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F0580 SS = D	Continued from page 2 and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to notify the medical provider with a change in condition for 1 of 1 resident (R33) reviewed for notification of change. Finding include: R33's face sheet provided on 3/24/26, included diagnosis of heart disease. R33's admission Minimum Data Set (MDS) dated 3/17/26, indicated severe cognitive impairment, clear speech, could understand and be understood. R33 required supervision or partial assistance for most activities of daily living. R33's physician orders did not include an order for transfer to the hospital. Facility standing orders did not provide guidance for transfer to the hospital. R33's care plan did not include focus areas for heart disease or respiratory concerns. Progress notes indicated no documentation that a provider had been notified for three consecutive transports to the local emergency department (ED): --On 2/22/26 at 2:15 p.m., R33 was transported by ambulance to the ED for bilateral lung crackles, wheezing and shortness of breath. Family member (FM)-A had been in attendance at the facility. Registered nurse (RN)-A who was also the nurse manager, had been notified. At 5:58 p.m., staff at the hospital called the facility to report R33 would be returning. --On 2/23/26 at 7:20 p.m., R33 was transported by ambulance to the ED for hoarse voice, phlegm crackling in throat, hard time clearing throat, diminished lung sounds and wheezing. FM-A had been called and updated, as well as facility on-call nurse. At 10:00 p.m., R33 returned to the facility. --On 2/24/26 at 8:39 a.m., R33 was transported by ambulance to the ED due to audible crackles in lungs and low oxygen saturation. FM-A had been notified. At 10:21 a.m., the hospital called the facility to inform staff R33 would be admitted for acute respiratory failure. On 3/11/26 at 2:58 p.m., R33 returned to the facility.	F0580	Continued from page 2 -Director of nursing and/or designee is the responsible party. -Corrective action to be completed by 4/24/2026.	04/24/2026

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F0580 SS = D	Continued from page 3 During an interview on 3/24/26 at 11:42 a.m., the director of nursing (DON) stated a provider would not necessarily be notified when a resident's condition changed requiring transfer to the ED. The DON stated R33 had frequent condition changes and his family had been notified. Requested change in condition policy, undated, which indicated facility staff made appropriate notification to the physician when there was a change in condition; changes in condition were reported to the physician. During an interview on 3/24/26 at 12:06 p.m., licensed practical nurse (LPN)-A stated when a resident's condition changed and needed to go to the hospital, nursing staff called the facility nurse on-call and/or DON, family member, and faxed the provider. In the fax, LPN-A stated the provider would be informed of what was going on with the resident and when the resident was sent to the hospital. LPN-A stated this was done all hours – days, evenings and nights. LPN-A stated she didn’t know who received the fax or when it was reviewed. LPN-A stated nursing staff would not call a provider to notify them of a residents change in condition or to ask for guidance prior to sending to the hospital, adding, "We just send them - we don't wait - so they get the care they need." During an interview on 3/24/26 at 12:29 p.m., the DON was asked what the facility policy on change in condition directed staff to do when a resident's condition changed. The DON stated the policy was to inform the provider and should be done real time, as the change was occurring. During an interview on 3/24/26 at 12:45 p.m., the DON reviewed the progress notes for the dates R33 had been transferred to the ED and stated a provider should have been contacted before anyone else had been notified. The DON acknowledged in some cases a provider who had knowledge of a resident might recommend medication or treatment first, and transport to the hospital might not be necessary. Facility Notification of Changes policy, undated, indicated it was the policy of the facility that changes in a resident's condition or treatment would be shared with the resident and/or resident representative according to their authority, and reported to the attending physician or delegate. Nurses and other care staff were educated to identify changes in a resident’s status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure the best outcomes of care for	F0580		04/24/2026

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F0580 SS = D	Continued from page 4 the resident. The objective of the policy was to ensure that facility staff made appropriate notification to the physician and notification to the resident and/or resident representative when there was a change in the resident's condition. The intent of the policy was to provide appropriate and timely information to the parties who will make decisions about care, treatment and preferences to address the changes.	F0580		04/24/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	F0641	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F641 Accuracy of Assessments - The process for satisfying this requirement has been reviewed and revised as needed, to ensure accuracy of MDS pressure ulcer assessments. - All residents with Pressure Ulcers have the potential to be affected if this requirement is not met. -There was a modification of R20 admission MDS completed. -All like residents reviewed for inaccurate coding of pressure ulcers, without new opportunities ide ntified.	04/24/2026

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F0641 SS = D	Continued from page 5 failed to accurately code the presence of a pressure ulcer on the admission Minimum Data Set (MDS) assessment for 1 of 3 residents (R20) reviewed for pressure ulcers. Findings Include: R20's admission Minimum Data Set (MDS) dated 1/22/26, indicated R20 was admitted to the facility on 1/16/26, no cognitive impairment, required supervision with personal hygiene, and dependent with dressing, toileting, and transfers; diagnosis included pressure ulcer of sacral region unspecified stage, and Section M-Skin Conditions indicated R20 had no unhealed pressure ulcers/injuries. R20's Interim Payment Assessment MDS dated 1/30/26, indicated one or more unhealed pressure ulcers, and one stage 3 pressure ulcer. R20's care plan dated 1/19/26, indicated pressure injury to buttocks and interventions included; Monitor skin integrity daily during cares, ...weekly skin inspection by nurse , ...treatment to open areas per order. R20's hospital summary report dated 1/15/26, indicated .....sacral wound was identified as the likely source of infection and pressure injury of skin of sacral region. R20's Admission/Initial Data Collection assessment dated 1/16/26, indicated wound on coccyx area measuring 4.5 cm (centimeter) x 1 cm. On 3/23/2026 at 4:10 p.m. R20 stated she had a pressure ulcer upon admission from a previous facility located on her buttocks. On 3/24/2026 at 10:50 a.m., licensed practical nurse (LPN)-A stated she was the current MDS nurse but did not complete R20's 1/22/26 MDS. LPN-A stated registered nurse (RN)-B completed the assessment remotely and confirmed the admission MDS should have reflected a pressure ulcer. On 3/24/2026 at 1:00 p.m., during a telephone interview RN-B stated they were a MDS nurse and completed R20's MDS dated 1/22/26, section M and marked “no” for pressure ulcer but acknowledged this was an error. RN-B stated the skin assessment indicated a pressure ulcer but failed to correctly code it as a pressure ulcer on the MDS, impacting evaluation and treatment coding. On 3/24/2026 at 1:10 p.m., during a telephone interview RN-C stated they were the MDS specialist and assisted with MDS training and education and confirmed R20's wound should have been coded as a pressure ulcer and confirmed it was miscoded. RN-C stated that accurate coding is necessary to develop the care plan and guide treatments and that staff are expected to follow the RAI (Resident Assessment Instrument) Manual. On 3/24/2026 at 1:33 p.m., the director of nursing (DON) stated expectations were that MDS	F0641	Continued from page 5 -RVHR MDS coordinator has been educated on section M (skin and wound) section of the MDS. -Audits to monitor compliance and sustainability for accuracy of MDS pressure ulcer assessments will be completed weekly for 4 weeks and monthly thereafter for 2 months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of the occurrence. - Director of nursing and/or designee is the responsible party. - Corrective action to be completed by 4/24/2026.	04/24/2026

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F0641 SS = D	Continued from page 6 assessments are accurate. On 3/24/26 at 2:02 p.m., the administrator indicated in an email that the facility does not have a specific MDS policy and relies on compliance with the RAI Manual for coding and accuracy.	F0641		04/24/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to follow ordered wound care treatments, failed to ensure availability and use of ordered supplies, and failed to notify the provider when treatments were not completed for a pressure-related wound for 1 of 3 residents (R10) reviewed for pressure ulcers. Findings include: R10's discharge assessment - return anticipated Minimum Data Set (MDS) dated 3/10/26, indicated no cognitive impairment, required substantial/maximal assistance with personal hygiene, dependent on assistance with transfers, utilized a wheelchair, diagnoses included sepsis, burn of third degree on the buttock; unhealed pressure ulcers/injuries, one stage 3 pressure ulcer that was present upon admission/entry or reentry. R10's entry tracking MDS dated 3/16/26, indicated on 3/16/26, R10 was readmitted from a short-term general hospital. R10's care plan revision dated 3/17/26, indicated	F0686	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer - The process for satisfying this requirement has been reviewed and revised as needed, to ensure necessary wound supplies are in supply and treatments are completed in compliance with physicians' orders to prevent/heal pressure ulcers. -Residents with pressure ulcerations have the potential to be affected if this requirement is not met. -R10's wound dressing was completed according to the provider's orders. -All like residents were reviewed for treatments completed to providers orders, with no other non-compliance identified.	04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Health And Rehabilitation Center Llc	**200 SOUTH DEKALB STREET , REDWOOD FALLS, Minnesota, 56283**

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F0686 SS = D	Continued from page 7 pressure ulceration to R (right) buttock and R dorsum foot and interventions included treatment to open areas per order. R10's inpatient hospital wound care note dated 3/11/26, nurse practitioner (NP)-C indicated new today is a wound present on the dorsum of his right foot. This appears to be related to pressure. R10's wound care follow up progress note dated 3/18/26, NP-C indicated ulceration on the right anterior foot after debridement measures 1 cm (centimeter) x 1.1 cm x 0.1 cm, 100% slough covered. To the ulceration present on the anterior right foot, lodosorb (used to clean wounds and promote healing of skin ulcers and wounds) was placed to the wound bed then Aquacel Ag Hydroftber (dressing absorbs fluid and bacteria from the wound and creates a moist environment that promotes healing) and protected with Mepilex silicone-based foam dressing. Change dressings every 3 days or if 50% saturated or greater, soiled or rolled edges that cannot be smoothed. Ulceration dorsum, right foot: 3. Wash hands, apply gloves, remove dressings, clean wound with 4 x 4 gauze soaked in wound cleanser 4. Apply lodosorb to the wound bed then cover with Aquacel Ag Hydrofiber 5. Cover with a Mepilex silicone-based foam dressing, can reinforce with tape as needed6. Change dressing every 3 days or if 50% saturated or greater, soiled or rolled edges that cannot be smoothed. R10's treatment administration record (TAR) dated 3/1/26-3/31/26, indicated start date 3/21/26, ulceration dorsum of R foot: 1) Gently cleanse w/ wound cleanser and gauze 2) Apply lodosorb to areas of slough and cover w/ Aquacel AG hydrofiber (calcium alginate) 3) Cover w/ adhesive foam dressing. every day shift every 3 day(s) for Ulceration Change PRN if greater than 50% saturated, edges rolled or missing. On 3/21/26, and 3/24/26, the TAR had a check mark with staff initials indicating the treatment was complete. On 3/23/26 at 1:32 p.m., R10 stated he had pressure areas on his foot, stated the area was improving, and confirmed staff were performing dressing changes and repositioning. On 3/24/26 at 8:27 a.m., licensed practical nurse (LPN)-A stated she had completed R10's dressing change on his foot that morning and the ordered lodosorb was unavailable. LPN-A stated she applied Aquacel and a foam dressing without the Iodosorb and had not notified the provider, wound care team, or registered nurse (RN)-A (facility nurse manager	F0686	Continued from page 7 -Education will be completed with licensed nurses utilizing the skin assessment and wound management policy. -Audits to monitor compliance and sustainability for necessary wounds supplies and completed treatments in compliance with physicians' orders for pressure ulcers will be completed weekly for 4 weeks and monthly thereafter for 2 months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of the occurrence. -Director of nursing and/or designee is the responsible party. -Corrective action to be completed by 4/24/2026.	04/24/2026

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F0686 SS = D	Continued from page 8 and wound care nurse) at that time. LPN-A stated the dressing change was ordered every three days and as needed. LPN-A further stated when R10 was readmitted to the facility after hospitalization, the right foot ulcer was present. On 3/24/26 at 2:31 p.m., LPN-A was observed entering the time clock room and stated she had completed her shift. LPN-A confirmed she had forgotten to contact the provider regarding unavailable supplies for R10's dressing change. LPN-A stated she would go back to contact the provider; however, she indicated the provider was not in the office and would be rounding the following day. LPN-A stated she planned to leave a note for the provider to address the dressing change but had not checked whether lodosorb had been ordered. On 3/24/26 at 3:11 p.m., the director of nursing (DON) stated staff are expected to follow physician orders, and if supplies are unavailable, an equivalent may be used, with documentation of what was completed and notification to the provider. On 3/24/26 at 3:55 p.m., RN-A, the facility wound care nurse, stated the facility utilizes an outside wound provider who evaluates residents approximately every two weeks. RN-A stated the provider assessed R10 on 3/18/26 and issued new wound care orders. RN-A further stated the wound care provider would have left necessary supplies, including lodosorb, at the facility for staff use. RN-A stated if lodosorb was not available, staff were expected to contact the pharmacy to reorder the product or contact the provider or wound clinic for an alternative treatment. On 3/24/26 at 4:05 p.m., observation of R10's room with RN-A revealed lodosorb was located in R10's room. On 3/24/26 at 4:26 p.m., during a telephone interview NP-C stated they had ongoing concerns and discrepancies between ordered and completed treatments of wounds at the facility. NP-C stated Iodosorb was necessary for debridement and prevention of further wound breakdown and infection. NP-C stated prior communication had occurred with the DON regarding concerns with wound care practices and that staff should notify the provider if treatments cannot be completed as ordered. NP-C stated they would have expected a phone call today when the dressing change could not be completed as ordered.	F0686		04/24/2026

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F0686 SS = D	Continued from page 9 On 3/24/26 at 4:31 p.m., the DON stated expectations were that physician orders should be followed but acknowledged prior instances of incorrect dressing application. The DON further stated NP-C had not raised concerns regarding incorrect supplies not being used, and the only concern previously discussed was a dressing was not fully secured and had shifted from the intended area of coverage. The DON confirmed some education had been provided to nursing staff regarding dressing changes but could not recall when or the specifics. On 3/24/26 at 6:16 p.m., RN-A was observed completing R10's dressing change to the right dorsum of the foot. Upon removal of the existing dressing, RN-A confirmed there was no evidence of Iodosorb present. RN-A stated the dressing would have appeared orange in color if the lodosorb was used. RN-A then completed the dressing change in accordance with NP-C's orders. The facility Skin Assessment & Wound Management Policy dated 2/25, indicated Ongoing Skin Issues - Follow ongoing treatments per provider order. - Update provider and resident/representative as needed. - Update care plan as needed	F0686		04/24/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to administer a physician-ordered medication for 1 of 1 resident (R37), when lorazepam (used to treat anxiety) was not administered. The facility did not notify the provider or leadership, or implement an alternative intervention, resulting in a medication omission for several days. Findings include: R37's face sheet provided on 3/24/26, included	F0760	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's	04/24/2026

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F0760 SS = D	Continued from page 10 diagnoses of congestive heart failure (when heart muscles cannot pump enough blood to meet the body's needs) and generalized anxiety. R37's annual Minimum Data Set (MDS) dated 11/5/25, indicated intact cognition, clear speech, could understand and be understood. R37 was either independent or needed partial assistance for most activities of daily living and was independent with walking. R37's handwritten physician order dated 12/12/25, (no time listed) indicated to start lorazepam 0.25 mg (milligram), 7:00 a.m. and 7:00 p.m. R37's care plan dated 11/10/24, indicated R37 was at risk for alteration in comfort and would have adequate pain relief. During record review, R37 had been experiencing anxiety for which lorazepam had been ordered on 12/12/25. Despite the order, R37 had not received the medication until 12/15/25. Progress note dated 12/12/25 at 2:48 p.m., indicated R37 has been seen by medical doctor (MD)-D. R37 had been more anxious due to shortness of breath and MD-D ordered to start lorazepam. Orders were faxed to pharmacy. Progress notes for the lorazepam subsequently indicated the following: -- Friday 12/12/25 at 2:48 p.m., orders faxed to pharmacy. -- Friday, 12/12/25 at 8:23 p.m., medication not available. -- Saturday, 12/13/25 at 11:15 p.m., pharmacy yet to deliver medication. -- Sunday, 12/14/25 at 12:13 p.m., medication will be delivered from pharmacy today. -- Sunday, 12/14/25 at 8:52 p.m., medication not available. -- Sunday 12/14/25, according to pharmacy, lorazepam had been delivered to the facility at 11:00 p.m. -- Monday, 12/15/25 at 8:09 a.m., registered nurse (RN)-A who was also the nurse manager indicated in a progress note, that written orders had been received from MD-D on 12/12/25, for lorazepam 0.25	F0760	Continued from page 10 credible allegation of compliance. F760 Residents are Free From Significant Med Errors - The process for satisfying this requirement has been reviewed and revised as needed, to ensure residents are administered physician ordered medications as prescribed and proper notifications to physicians are made as required if a medication is not administered. -Residents who are receiving Lorazepam/Ativan have the potential to be affected if this requirement is not met. -R37 has since been discharged from the facility. -All alike residents receiving Lorazepam / Ativan were reviewed for non-compliance with no other issues identified. -Education will be provided to licensed nurses on the Monarch Healthcare Management medication and treatment orders policy. -Audits to monitor compliance and sustainability for medication administration as prescribed and proper notifications to physicians are made as required will be completed weekly for 4 weeks and monthly thereafter for 2 months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of the occurrence. -Director of nursing and/or designee is the responsible party. -Corrective action to be completed by 4/24/2026.	04/24/2026

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F0760 SS = D	Continued from page 11 mg, however the medication with instructions received from pharmacy indicated the dose to be lorazepam 0.5 mg. RN-A contacted pharmacy and was informed the reason was because the e-prescription from MD-D indicated a dosage of 0.5 mg. RN-A reached out to the clinic to obtain clarification of dosage from MD-D, but no response was received. -- Monday 12/15/25 at 9:34 a.m., still needing clarification on dose. -- Monday 12/15/25 at 11:23 a.m., progress note by RN-A indicated she attempted to reach MD-D, but when no answer, sent an urgent fax. -- Monday 12/15/25 at 2:44 p.m., progress note by licensed practical nurse (LPN)-A indicated family member (FM)-B and FM-C had questioned why R37 had not received lorazepam when it had been ordered on 12/12/25. LPN-A informed them the lorazepam order needed clarification on the dosage as the facility and pharmacy had different orders. FM-B questioned why that had not been handled on Friday or over the weekend. LPN-A explained to FM-B nursing was working on it. FM-B stated R37 should not have to ask for anything, should just get the lorazepam. R37 rated her pain 3/10 and denied needing additional pain medication. FM-C stated to LPN-A this should not have happened and R37 should have had her medication right away on Friday - "She's 96 years old; she should be living her best life." FM-B told LPN-A she was told over the weekend that the medications would be "handled and straightened out but I just keep getting lied too." LPN-A informed both FM-B and FM-C she would speak with the social worker and DON (director of nursing) regarding their complaints. -- Tuesday 12/16/25 at 4:01 p.m., progress note indicated MD-D's nurse was contacted about the continued discrepancy in doses for lorazepam (0.25 mg vs 0.5 mg). Requested MD-D's nurse to ask MD-D for an updated order regarding which dose to administer. -- Tuesday 12/16/25 at 7:00 p.m., per the medication administration record (MAR), the first dose of lorazepam was documented as being administered. During an interview on 3/24/26 at 4:29 p.m., RN-A recalled R37 and reviewed her progress notes in the electronic medical record from 12/12/25 to 12/15/25. RN-A stated there had been a discrepancy in the order for lorazepam dosages between what the	F0760		04/24/2026

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F0760 SS = D	Continued from page 12 facility received from the physician and what the pharmacy received from the physician. RN-A stated she had first been aware of the concern of R37 not receiving lorazepam over the weekend when she arrived to work on 12/15/25. RN-A didn't know if staff on duty over the weekend had attempted to contact a provider to clarify the order, or if they contacted leadership, such as the DON to assist with problem-solving. During an interview on 3/24/26 at 5:18 p.m., with the DON and administrator, both stated they had not been aware of the medication discrepancy and subsequent failure to administer a physician-ordered medication. The DON who was on-call that weekend, did not remember if he had received a call from nursing staff. The DON stated he would have expected staff to notify the provider and him, and acknowledged lorazepam was important to R37 who had just started on hospice and who experienced anxiety related to shortness of breath. During a telephone interview on 3/24/26 at 6:09 p.m., FM-C expressed concern about R37 not receiving lorazepam in a timely manner after it had been ordered by the physician. FM-C couldn't understand why staff were not able to resolve the problem with the order over the weekend (weekend of 12/12/25). FM-C stated once R37 did receive the lorazepam, it took the edge off the pain and anxiety, and she was able to die with dignity. On 3/24/26 at 6:15 p.m., and 6:35 p.m., attempted to reach nursing staff who had worked the weekend of 12/12/25, and who had documented progress notes about lorazepam not being available, but did not receive a return call as of 3/25/26. During an interview on 3/25/26 at 1:15 p.m., customer service representative at Polaris Pharmacy stated an original order from the facility had been received on 12/12/25, but was not a valid prescription because it did not include a provider signature, quantity of medication, or DEA (drug enforcement administration) number which were required for controlled medications. A "blank" e-script was then routed to the ordering provider, MD-D, to inform him. On 12/13/25, at 10 p.m., an e-prescription was received from MD-D for lorazepam 0.5 mg by mouth in the morning and one tablet 0.5 mg in the evening. Maximum daily dose 1 mg. Quantity 60 tablets. Since it was after delivery time, the medication had not been delivered. According to the representative, on 12/14/25 at 11:00 p.m., the lorazepam had been delivered to the facility for R37.	F0760		04/24/2026

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F0760 SS = D	Continued from page 13 Facility Medication and Treatment Orders policy dated 2/2024, indicated order for medications would be consistent with principles of safe and effective order writing. Orders must include name and strength of the drug; number of doses, start and stop date, and/or specific duration of therapy; dosage and frequency of administration; route of administration; clinical condition or symptoms for which the medication is prescribed. Only authorized personnel shall call in orders for prescribed medications to the pharmacy.	F0760		04/24/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 21, 2026

Administrator
River Valley Health And Rehabilitation Center LLC
200 SOUTH DEKALB STREET
REDWOOD FALLS, MN 56283

RE: CCN: 245237
Cycle Start Date: March 24, 2026

Dear Administrator:

On May 6, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Email: sarah.lane@state.mn.us