



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 25, 2025

Administrator
River Valley Health And Rehabilitation Center
200 South Dekalb Street
Redwood Falls, MN 56283

RE: CCN: 245237
Cycle Start Date: February 5, 2025

Dear Administrator:

On March 24, 2025, the Minnesota Departments 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,

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



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March 25, 2025

Administrator
River Valley Health And Rehabilitation Center
200 South Dekalb Street
Redwood Falls, MN 56283

Re: Reinspection Results
Event ID: QSEC12

Dear Administrator:

On March 24, 2025 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 February 5, 2025. 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 delivered
February 21, 2025

Administrator
River Valley Health And Rehabilitation Center LLC
200 South Dekalb Street
Redwood Falls, MN 56283

RE: CCN: 245237
Cycle Start Date: February 5, 2025

Dear Administrator:

On February 5, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 May 5, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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Electronically delivered
February 21, 2025

Administrator
River Valley Health And Rehabilitation Center LLC
200 South Dekalb Street
Redwood Falls, MN 56283

Re: State Nursing Home Licensing Orders
Event ID: QSEC11

Dear Administrator:

The above facility was surveyed on February 3, 2025 through February 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

Health Regulation Division

Minnesota Department of Health

1400 East Lyon Street, Suite 102

Marshall, Minnesota 56258-2504

Email: nicole.osterloh@state.mn.us

Office: 507-476-4230

Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 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
E 000	Initial Comments On 2/3/25 through 2/5/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was 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.	E 000			
F 000	INITIAL COMMENTS On 2/3/25 through 2/5/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580			3/14/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/03/2025

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

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F 580	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).	F 580			

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F 580	Continued From page 2 §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, 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 observation, interview and document review, the facility failed to timely notify the physician of new onset pressure ulcers for 1 of 1 resident (R7). Findings include: R7's 11/15/24, annual Minimum Data Set (MDS) identified R7 was cognitively intact and had a diagnosis of dementia, anxiety, depression, psychotic disorder (impaired relationship with reality, confusion, hallucinations and delusions) and malnutrition. R7 was at risk for pressure ulcer development and no pressure ulcers at the time of the assessment. R7 required supervision or touching assistance with bed mobility, transfers, and toileting. R7 had an indwelling catheter during the look back period. R7's current, undated, care plan identified on 8/9/24, he was noted to be at risk for alteration in mobility related to weakness and dementia. At that time, R7 was independent with bed mobility, had grabs bars to assist with bed mobility, could safely enter and exit his bed, and was independent with locomotion in his wheelchair. R7's 11/14/24, Target Behavior Form identified	F 580	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 Executive Director 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		

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F 580	Continued From page 3 R7's wife had passed recently, and he was noted to have appeared to be sad. R7 displayed anxiety related to his wife's funeral service. R7 appeared helpless and dependent on staff for his care needs. R7's 11/14/24, Braeden Scale for Predicting Pressure Ulcer Risk assessment score was 19, which indicated average risk (lowest level risk which is not abnormal compared to healthy individuals). Review of 12/18/24, faxed notification to the physician (2 days after discovery) identified R7 had open areas to the left hip, measures 1.5 centimeters (cm) X 0.2 cm x 0.1 cm and the right hip, measures 2.4 centimeters (cm) x 1.5 cm x 0.1 cm depth with slough (yellowish white material of dead cells and debris) of the wound bed, serosanguineous (bloody clear) drainage to dressing, and erythema (redness) to site. Recommendations by staff to the MD for treatment were to remove the old dressing, cleanse site with wound cleanser and gauze, apply Medi-honey to the wound bed, cover with non-adhesive foam dressing and change every 3 days or as needed until resolved. Staff proposed to refer to wound care for evaluation and R7 was to take liquid protein 30 milliliter (ml) twice a day. The physician response to the fax identified he agreed with the facilities plan "as above." The corresponding nurses note from 12/18/24 showed staff also added liquid protein (increases healing) and notified the MD and family of the open wound areas. Interview on 2/04/25 at 1:11 p.m., with medical director (MD)-A identified he routinely received notifications from the facility by phone and fax.			F 580	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure that the facility notifies the physician timely of any new onset of pressure ulcers. -R7's family and physician were immediately updated with the current status of the pressure ulcer. Processes and procedures were reviewed and revised as needed to ensure future instances are avoided. - All residents of the facility who are at risk of pressure ulcers have the potential to be affected if this requirement is not met. -Necessary River Valley staff have received education on timely reporting of any new pressure ulcers to the family and the physician. -An audit was completed to ensure no other residents were affected. -Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 3/14/25		

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F 580	Continued From page 4 MD-A identified the facility had not notified him, initially, of R7's wound. Observation and interview on 02/05/25 at 09:33 a.m., with wound care nurse and nurse practitioner (NP) had removed the foam dressing on R7's right hip. R7's wound appeared red around the area the size of a dime. The surrounding skin and edges were intact had no drainage from the wound. NP obtained measurements and applied a non-adhesive foam dressing and stated R7'S right hip was healed. The NP and wound care nurse had repositioned R7 to his left side. NP had removed the foam dressing on his left hip. The wound appeared as a quarter sized shape. The wound had a small slit in the wound bed with a small amount of blood draining from the wound. The edges of the wound were intact. The NP cleansed the wound, obtained measurements and applied a non-adhesive foam dressing to R7's left thigh. NP and the wound nurse discarded their supplies in the trash bin and had removed their PPE. NP and wound care nurse had sanitized their hands after leaving R7's room. NP identified R7's left hip wound was a stage 3 pressure ulcer and had improved significantly with R7's current wound treatments and wound care visits. She identified R7's left hip was to heal approximately in 1 month. NP identified R7 had cognitive deficits and appeared to lie in his bed more often since his wife had passed. She confirmed the addition of the air mattress (implemented on 12/27/24) had helped alleviate the pressures of his bilateral hips as R7 favored side lying position in bed. Interview on 2/05/25 at 3:28 p.m., with administrator identified she would expect nursing staff to follow facility policy and to notify the			F 580			

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F 580	Continued From page 5 provider of a new onset wound needed to be assessed immediately to prevent further skin breakdown. Review of March 2024 Skin Assessment & Wound Management policy identified nursing staff were to notify the provider for treatment orders.	F 580			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ventilator equipment supply water was not expired for 1 of 1 (R18). Findings include: R18's 11/27/24, annual Minimum Data Set (MDS) identified R18 had a diagnoses of respiratory failure and chronic obstructive pulmonary disease (COPD) and was cognitively intact. R18 had used a non-invasive mechanical ventilation system, along with O2 therapy. R18's current, undated care plan identified R18 used a ventilator for her COPD. The nursing staff	F 695	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 Executive Director 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.		3/14/25

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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F 695	Continued From page 6 were directed to replace the tubing and O2 chamber, clean and inspect the tubing, and notify the respiratory company of any damage to the machine or if there staff had any concerns. Observation and interview on 2/03/25 at 12:19 p.m., with licensed practical nurse (LPN)-A while in R18's room and later in the storage room, identified R18 had a ventilator (a non-invasive ventilator with a mask used to assist COPD patients with easier breathing) which sat on the table next to R18's bed. The ventilator had tubing attached to a bag of sterile water. The water had an expiration date of 10/1/24. LPN-A identified the water bag was changed "every few months". She was not aware the water had expired 4 months ago. R18 had an extra water in the storage room to replace the expired bag currently hung in R18's room. LPN-A walked to the storage room, opened a cardboard box that had 1 water left that also had an expiration date of 10/1/24. She confirmed the facility should be checking for expiration dates and should not use expired sterile water. R18's active orders, identified the nursing staff was to order supplies (to include water) every 2 months, inspect and clean the ventilator weekly or sooner as needed, change the oxygen (O2) tubing and clean the filter weekly, and place a date and time on the water bag to note when it was put into use. Interview on 2/3/25 at 1:14 p.m., with R18 had used the ventilator to assist her with her breathing as she had difficulty while sleeping at night. She would apply the face mask and the nursing staff would turn on the machine when she went to bed approximately at 9:30 p.m.. She recalled the water having been changed a few days ago by a	F 695	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 F695 - The process for satisfying this requirement has been reviewed and revised as needed, to ensure ventilator equipment supply water is not expired. -R18 immediately had ventilator supply water changed. -Any residents who use a ventilator have the potential to be affected if this requirement is not met. -Necessary River Valley staff have received education in regard to checking for expirations on ventilator equipment supply water. - Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 3/14/25.		

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F 695	Continued From page 7 staff. Interview on 2/3/25 at 6:08 p.m., with registered nurse (RN)-A identified she was informed by LPN-A that R18's water had expired. R18 had a scheduled delivery of water to arrive the next day. R18 had nursing orders that reminded nurses to change the water on the Treatment Administration Record (TAR). R18's November 2024, December 2024, and January 2025, TAR identified nursing staff were to check the water every shift. Staff were to hang a new water bag if low and input a "Y" or "N" if a new water had been placed. The log identified staff had last placed a new water on R18's ventilator on 11/4/25. There was no indication the TAR included for staff to check the expiration on water. Interview on 2/5/25 at 9:37 a.m., with the ventilator company identified he was not informed by the facility of the expired sterile water. R18 had been a customer since April 2020 and had received a box of sterile water every 6 months. The ventilator required staff to use sterile water for the closed system and staff were to to change the bag once the contents were empty or if it was expired. Observation and interview on 2/05/25 at 10:12 a.m., with the administrator in R18's room identified the sterile water was expired as of 10/01/24. She was not made aware of the situation and would have expected to be notified the ventilator company and order replacement water. She agreed it was not an acceptable practice of using expired products for residents.	F 695			

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F 695	Continued From page 8	F 695			
F 727 SS=F	A policy for the ventilator machine and requested but none was provided. RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day for 5 of 7 days reviewed. This had the potential to affect all 32 residents living in the facility. Findings include: Review of the nursing staff schedules and time punches for 8/29/24, 9/8/24, 9/28/24, 9/29/24 and 1/11/25 identified there was no evidence an RN had worked for a minimum of 8 hours per day. Interview on 2/5/25 at 11:23 a.m., with RN-B identified the facility was short on RN coverage and either she or the director of nursing (DON) would attempt to cover those shifts as charge	F 727			3/14/25
			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 Executive Director 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		

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F 727	Continued From page 9 nurse or floor nurse, however some days no replacements could be assigned. She confirmed for the above dates, there was no RN working. Interview and document review on 2/5/25 at 12:38 p.m., with the administrator confirmed the facility failed to provide consecutive 8 hours per day of RN coverage on the above mentioned dates due to the lack of available RN staff. The facility had been attempting to recruit staff, and they also had staff hired who then quit. The administrator confirmed the facility attempted to staff according to their facility assessment, and attempted to fill those vacancies when able. A policy addressing RN coverage or staffing was requested but not provided by the end of the survey.	F 727	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. F727 - The process for satisfying this requirement has been reviewed and revised as needed, to ensure a registered nurse (RN) is on duty a minimum of 8 consecutive hours each day. - All residents of the facility have the potential to be affected if this requirement is not met. -Necessary River Valley staff have received education on the requirement to ensure a registered nurse (RN) is on duty a minimum of 8 consecutive hours each day. -An audit was immediately completed to ensure that RN coverage is in place for the upcoming schedule. -Processes and procedures were reviewed and revised as needed to ensure future instances are avoided. --Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party.		

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F 727	Continued From page 10			F 727			
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and meet the needs of 1 of 1 (R7) resident reviewed for the provision of medically related social services, who was grieving the death of a significant other. Findings include: R7's 11/15/24, annual Minimum Data Set (MDS) identified R7 was cognitively intact and had a diagnoses of dementia, anxiety, depression, psychotic (impaired relationship with reality, confusion, hallucinations and delusions) disorder and malnutrition. R7 had little interest or pleasure in doing things and had trouble falling or staying asleep or sleeping too much 12 to 14 days. R7 had felt down, depressed, hopeless, had a poor appetite, felt bad about himself, or have let himself or his family down, had trouble concentrating on things, moving or speaking slowly that other people would not have notice, and thoughts that R7 would be better off dead or wanting to hurt himself in some way never to 1 day. R7's current, undated care plan identified R7 was at risk for alteration of mood and behavior. Staff			F 745	-Corrective action will be completed by 3/14/25 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 Executive Director 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		3/14/25

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F 745	Continued From page 11 were to provide redirection, validate R7's feelings with regards to his wife's passing, monitor side effects related to medication management, be aware of mood and behavior changes, monitor and respond to unmet needs and contact R7's family with concerns. There was no mention staff had appropriately monitored R7's behaviors or mood for his ability to cope with his wife's death. R7's 11/14/24, Target Behavior Form identified R7's wife had passed recently and appeared sad. R7 displayed anxiety related to his wife's funeral service. R7 "appeared helpless and dependent on staff" for his care needs. R7's 11/14/24, Patient Health Questionnaire (PHQ-9) identified he was mildly depressed. R7's 11/15/24 at 1:53 p.m., progress note identified R7 was informed by the social services designee (SSD) and R7's stepson that his wife had passed. R7 wanted to be left alone and declined SSD to sit with him. There were no further notes from social services for any visits. R7's 11/22/24, progress note by physician (MD)-A identified due to R7's dementia, he may not be able to comprehend his wife had passed. R7 had behaviors and hallucinations and was to continue on his current medication management. There was no mention MD-A advised staff to frequently check his coping with his wife's passing as that may require enhanced monitoring of R7's psychosocial needs. R7's activities log identified on: 1) November 2024, R7 had refused to participate in activities 18 times, lower than normal. 2) December 2024 had refused to participate in	F 745	F745 - The process for satisfying this requirement has been reviewed and revised as needed, to ensure that residents who are grieving the death of a significant other are provided the option of medically related social services. -Residents who are grieving the loss of a significant other may be affected if this regulation is not met -R7 was immediately provided emotional support, and his significant others funeral service was held at the facility. - Re-education was provided to the Social Worker to ensure that residents are receiving any medically related Social Services when needed. -Necessary River Valley staff including the administrator have received education utilizing the regulation -Oversight by the Administrator will be done as needed to ensure that the regulation to provide social services to residents in need is achieved. -Compliance audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Social Service Director or designee is responsible party. -Corrective action will be completed by 3/14/25		

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F 745	Continued From page 12 activities 19 times, lower than normal. 3) January 2025 had refused to participate in activities 9 times but was beginning to improve with participation. Observation on 2/03/25 at 7:11 p.m., identified R7 was asleep in bed. Interview on 2/03/25 at 7:31 p.m., with trained medication aide (TMA)-A wife had passed last November. R7 and his wife had been married for 30 years. The facility had a memorial service for her with R7 in attendance. She identified R7 appeared withdrawn and did not attend daily activities he normally would and ate his meals in his room. Interview on 2/04/25 at 1:11 p.m., with medical director (MD)-A identified he would see R7 on physician rounds. Often R7 would often be asleep. MD-A noted R7 appeared sad and withdrawn after his wife's death and agreed staff should monitor R7 for his psychosocial needs and potential withdrawal and provide medically related social services. Interview on 2/04/25 at 4:42 p.m., with social services designee (SSD) identified R7 had used telehealth services in 2023 for his mental health. She was present in R7's room along with R7's family when they had informed R7 that his wife has passed. SSD identified she frequently checked in on R7, but noted she had not documented any visit. She noted she had not reviewed R7 psychosocial or behavioral needs after R7's wife had passed and residents coping with the loss of a loved one should be monitored for negative effects on thier well-being.	F 745			

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F 745	Continued From page 13 Interview on 2/05/25 at 3:07 p.m., with licensed practical nurse (LPN)-C identified R7 was self-isolating in his room. R7 was aware his wife had passed but at the time it occurred, it appeared to have no effect on him. She identified a referral for mental health services was discussed at team meetings but they determined those would not be appropriate for R7 and stated it would "not make a difference" due to his dementia and his past medical history of electro-shock therapy. Review of Social Service Director job description identified the designee was to provide 1:1 visit with residents to assess psychosocial needs and to provide reassurance, support of resident/families grieving, encourage family involvement and support, communicate to appropriate facility staff psychosocial needs and problems to each resident and make referrals to the community, individuals or agencies to meet residents' psychosocial needs. Interview on 2/05/25 at 3:28 p.m., with administrator had no policy related to bereavement services. She identified staff had not received direction on how to assist R7 with his grieving.	F 745			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and	F 851			3/14/25

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F 851	Continued From page 14 other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is	F 851			

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F 851	Continued From page 15 engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate staffing data based on payroll and other verifiable, auditable data during 1 of 1 quarter reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. This had the potential to affect all 32 residents living in the facility. Findings include: Review of the July 2024, Electronic Staffing Data Submission Payroll-Based Journal (PBJ) Frequently Asked Questions, located at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/pbj-policy-manual-faq-11-19-2018.pdf, identified reporting shall be based on the employee 's primary role. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out when needed). Facilities shall still report just the total hours of that employee based on their primary role. However, CMS recognizes that staff may completely shift their primary role in	F 851	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 Executive Director 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		

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F 851	Continued From page 16 a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). Review of staffing schedules and timecard verifications identified the DON was noted having been on duty from 6:00 a.m. - 6:00 p.m., (12 consecutive hours) working as a staff RN on 8/4/24. Her name had been handwritten on the schedule as an active nurse, and review of her timecard identified she was clocked in during that time. However, it was noted she was not logged into the correct identified role. The DON's active nursing shift on 8/4/24 had not been included on the submitted PBJ report resulting in an inaccuracy. Interview on 2/5/25 at 8:15 a.m., with the administrator identified the director of nursing (DON) and Minimum Data Set (MDS) coordinator both covered to fill RN hours. The DON did not log hours differently or potentially notify the business office unless she was actively working as a fill for the RN position. This resulted in lack of documented RN coverage when she was not appropriately coded in their payroll based journal. The Administrator confirmed the PBJ was inaccurate for 8/4/24 and provided the schedule and timecard of the DON who had been on duty for 12 consecutive hours filling that role of the required RN Coverage. Interview on 2/5/25 at 8:49 a.m., with the human resources (HR) director identified she submitted the employee hours (time clock hours) after	F 851	submitted as the facility's credible allegation of compliance. F851 s/s F -The process for satisfying this requirement has been reviewed and revised as needed to ensure the facility submits to CMS complete and accurate direct care staffing information each quarter. -This had the potential to affect all residents, staff, and visitors -The facility will submit complete and accurate PBJ data in future quarters. -Necessary River Valley staff have been reeducated to the requirement and regulation utilizing the CMS submission guide and Monarch Healthcare Management PBJ submission guide. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed by 3/14/2025.		

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F 851	Continued From page 17 receiving them from the corporate office. She logged into PBJ, uploaded the files, and printed the CASPER (Certification and Survey Provider Enhanced Reporting) (A quality measure report that provides information about a skilled nursing facility's performance) report to confirm her submission had been accepted. She also reviewed an individual staff hours report for accuracy of timecards. She reported she was not aware of an error in reporting until the end of the quarter when a report was run. Review of the current, undated PBJ policy identified staffing data was generated and submitted from their electronic timekeeping system and submitted to the centers for Medicare and Medicaid Services (CMS) according to the guidelines provided.	F 851			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880			3/14/25

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F 880	Continued From page 18 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880			

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F 880	Continued From page 19 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate personal protective equipment (PPE) was used during a sterile dressing change for 1 of 1 resident (R85). Findings include: R85 was admitted on 1/30/25 for orthopedic aftercare with diagnoses of infection in his left hip following an arthroplasty, (a surgical procedure to replace a joint with an artificial one), absence of his left hip joint, rheumatoid arthritis, and local infection of his skin and subcutaneous tissue. 85's admission orders identified staff were to follow Enhanced Barrier Protections ((EBP), infection control (IP) control practices that use PPE to reduce the spread of multi-resistant organisms (MDROs)), while caring for IV lines and during performance of high contact personal cares. R85 had a peripherally inserted central catheter ((PICC), a flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart). through which his antibiotic medication was administered. The sterile dressing on his left upper arm, PICC line dressing was to be changed weekly with documentation placed in the progress notes.	F 880	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 Executive Director 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. F880		

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F 880	Continued From page 20 Review of R85's current, undated care plan identified he was on EBPs, due to a surgical wound on his left hip, and a PICC in his left upper arm. Interventions directed staff to wear PPE according to EBP and administer the IV medication (Ceftriaxone 2 grams (GM) every 24 hours), through 3/7/25. Staff were to monitor the PICC insertion site and report any signs of infection, discomfort, or adverse reactions.. Observation on 2/3/25 at 5:11 p.m., with registered nurse (RN)-B as she performed a sterile dressing change to R85's PICC site. A sign was posted on the outside of R85's door identifying EBP and listing the PPE to be worn for any close contact procedures. PPE to be worn included a mask, gown and gloves. The supplies were located on a cart outside the resident room. RN-B gathered supplies to perform the sterile dressing change, entered R85's room and explained the dressing change procedure. RN-B was wearing a mask upon entering the room, washed her hands and applied gloves, but no gown. She then cleansed the surface of the bedside table with Sanicloth wipes prior to placing the dressing change items on the surface. RN-B had R85 also mask, changed gloves and performed hand hygiene appropriately. She changed the dressing and performed the indicated measurements using sterile technique. RN-B finished the procedure by flushing a new end cap, applying it to the PICC line and flushing the line with sterile saline, then dated and initialed the dressing and cleaned up her supplies. Interview on 2/3/25 at 5:45 p.m., with RN-B identified R85 was on EBP due to his surgical hip wound and PICC line. She reported EBP PPE	F 880	-The process for satisfying this requirement has been reviewed and revised as needed, to ensure River Valley staff use appropriate PPE during sterile dressing changes. -Residents residing in this facility who received dressing changes have the potential to be affected if this procedure is not performed in accordance with policy/procedure, and standards of practice. -R85 was reviewed by qualified River Valley staff and there were no adverse effects. -Necessary River Valley staff received education on how and when to properly DON/DOFF PPE. - Audits will be completed to ensure compliance with this requirement. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 3/14/25.		

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F 880	Continued From page 21 would include a gown, gloves and mask to be worn when providing any personal care especially if there was a change for body fluid contact. RN-B identified she had not worn a gown when performing the PICC dressing change, and she was not certain why, but stated she should have. She identified she was nervous at being observed and had not though about it. Interview on 2/4/25 at 9:16 a.m., with trained medication aid (TMA)-A identified if a resident had been placed on EBP, PPE required would include a mask, gown, and gloves and that would be for any task requiring personal contact with the resident. Interview on 2/4/25 at 11:11 a.m., with TMA-B identified R85 was on EBP due to having a PICC line and any care provided requiring contact would require use of a gown, mask and gloves. She identified there was also a sign posted on the outside of the door when a resident was on EBP and PPE was located outside the door. she reported the sign was bright colored and visible when approaching the room, because he liked to have his door closed. Interview on 2/4/25 at 11:28 a.m., with licensed practical nurse (LPN)-A identified R85 was on EBP due to a surgical wound on his left hip and he had a PICC line for administration of IV antibiotics. LPN-A reported the dressings were checked every day, but the hip dressing was not removed and the PICC line dressing was changed by the RN. Interview on 2/4/25 at 3:00 p.m., with the infection preventionist (IP) identified R85 was on EBP due to his hip infection and having a PICC line in	F 880			

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F 880	Continued From page 22 place for antibiotic administration. She identified he had a return appointment with the infection prevention MD on Friday 2/7/25 and they would be receiving additional information following that visit. The IP identified if a resident was placed on EBP staff were to wear a gown, gloves and mask with any procedure or care requiring close contact. If there was a potential for splashing, goggles/face shield were to be added. She reported her expectation for staff to wear appropriate PPE even if they were not working specifically with the PICC line, but gave the example of assisting with bathing, transferring, or any high contact activity. Review of the current, undated Enhanced Barrier Precautions policy identified to avoid transmission of multi-drug-resistant organisms. All staff have received training on EBP at the time of hire and it is repeated annually. Signage was to be posted on either the door or wall outside a resident's room to identify the type of precautions, what PPE was indicated, and the high-contact activities that required the use of PPE. The IP was to complete periodic monitoring to ensure compliance and provide additional training if indicated. EBP were to remain in place for the duration of the resident's stay or until a wound was healed or the medical device discontinued.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883			3/14/25

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F 883	Continued From page 23 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883			

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F 883	Continued From page 24 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents (R21, R31) were offered and/or provided updated vaccinations for pneumococcal disease in accordance with the Centers for Disease Control (CDC) vaccinations. Findings include: R21's Minimum Data Set (MDS) dated 1/15/25, indicated R21 was admitted on 10/19/24, was currently 93 years old, had intact cognition and diagnoses of renal failure and diabetes which puts her at higher risk for pneumococcal diseases. It further indicated her pneumococcal vaccinations were up to date. R21's Minnesota Immunization report dated 12/5/24, indicated R21 received the pneumococcal polysaccharide vaccine (PPSV 23) on 9/20/12 and the pneumococcal conjugate vaccine (PCV13) on 10/20/17. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/4/25, identified based on R21's age and vaccine history: though the vaccines were considered complete, based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least	F 883	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 Executive Director 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. F883		

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F 883	Continued From page 25 5 years after the last pneumococcal vaccine dose. R21's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. R31 R31's admission Minimum Data Set (MDS) dated 12/11/24, indicated R31 was admitted on 12/5/24, was currently 84 years old, had intact cognition and diagnoses of chronic pneumothorax, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen which puts him at a higher risk for pneumococcal diseases. It further indicated R31's pneumococcal vaccinations were up to date. R31's Minnesota Immunization Report dated 5/18/24, indicated R31 received the PPSV23 on 1/19/1999 and the PCV13 on 7/23/15. The CDC's PneumoRecs VaxAdvisor for Vaccine Providers dated 2/4/25, identified based on R31's age and vaccine history: though the vaccines were considered complete, based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. R31's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. During interview on 2/5/25 at 9:35 a.m., the administrator stated the vaccinations the facility offered were listed in the admission packet and	F 883	- The process for satisfying this requirement has been Reviewed and revised as needed, to ensure that the facility offers updated vaccines upon admission and any other additional vaccines in accordance with the Centers for Disease Control Vaccinations. -Failure to meet this requirement has the potential to affect all residents within the facility. - Necessary River Valley staff have received education on the importance of to ensuring residents are being offered pneumococcal vaccinations according to timing to CDC immunization guidance. -- Audits will be completed five (5) times per week for two (2) weeks; two (2) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Director of Nursing or designee is responsible party. -Corrective action will be completed by 3/14/2025		

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F 883	Continued From page 26 the admitting nurse was responsible for checking to see if the resident has had those vaccinations or not and either administering them or having them sign a declination form. If the resident declined the vaccinations, the nurse was responsible for providing education on the risk and benefits and documenting it in their medical record. During interview on 2/5/25 at 8:15 a.m. the health information manager (HIM) stated when a resident was admitted to the facility, they are offered all vaccinations (COVID, pneumococcal, influenza, etc.) and were required to sign a consent form. If they decline the vaccination, staff should educate the resident on the risk versus (vs) benefits. If they decide to receive the vaccinations, the facility was responsible for getting a doctor's order and then administering it. During interview on 2/6/25 at 11:27 a.m., the infection preventionist (IP) stated when there was a new admission, the facility offered the pneumococcal, influenza, and COVID vaccinations. If the resident chose to receive the vaccinations, a consent form was signed by either the resident or the resident's representative and the vaccine was administered. If the resident declined, they document it on the bottom of the form and education was provided regarding the risk vs benefits. The IP verified the medical record for R21 and R31 lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines. The facility's policy regarding pneumococcal vaccinations dated 2/2024, indicated it's purpose was to follow recommendations of the Advisory Committee on immunization Practices (ACIP),	F 883			

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F 883	Continued From page 27 Centers for Disease Control (CDC) and/or the state Department of Health for prevention of Pneumococcal disease by identifying those residents at risk for Pneumococcal disease and offering Pneumococcal vaccination.	F 883			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: On 2/3/25 through 2/5/25, a licensing 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 correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

03/03/25

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2 000	Continued From page 1 identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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	2 000			

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: 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, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265			3/14/25

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2 265	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely notify the physician of new onset pressure ulcers for 1 of 1 resident (R7). Findings include: R7's 11/15/24, annual Minimum Data Set (MDS) identified R7 was cognitively intact and had a diagnosis of dementia, anxiety, depression, psychotic disorder (impaired relationship with reality, confusion, hallucinations and delusions) and malnutrition. R7 was at risk for pressure ulcer development and no pressure ulcers at the time of the assessment. R7 required supervision or touching assistance with bed mobility, transfers, and toileting. R7 had an indwelling catheter during the look back period. R7's current, undated, care plan identified on 8/9/24, he was noted to be at risk for alteration in mobility related to weakness and dementia. At that time, R7 was independent with bed mobility, had grabs bars to assist with bed mobility, could safely enter and exit his bed, and was independent with locomotion in his wheelchair. R7's 11/14/24, Target Behavior Form identified R7's wife had passed recently, and he was noted to have appeared to be sad. R7 displayed anxiety related to his wife's funeral service. R7 appeared helpless and dependent on staff for his care needs. R7's 11/14/24, Braeden Scale for Predicting Pressure Ulcer Risk assessment score was 19,	2 265	Corrected		

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2 265	Continued From page 4 which indicated average risk (lowest level risk which is not abnormal compared to healthy individuals). Review of 12/18/24, faxed notification to the physician (2 days after discovery) identified R7 had open areas to the left hip, measures 1.5 centimeters (cm) X 0.2 cm x 0.1 cm and the right hip, measures 2.4 centimeters (cm) x 1.5 cm x 0.1 cm depth with slough (yellowish white material of dead cells and debris) of the wound bed, serosanguineous (bloody clear) drainage to dressing, and erythema (redness) to site. Recommendations by staff to the MD for treatment were to remove the old dressing, cleanse site with wound cleanser and gauze, apply Medi-honey to the wound bed, cover with non-adhesive foam dressing and change every 3 days or as needed until resolved. Staff proposed to refer to wound care for evaluation and R7 was to take liquid protein 30 milliliter (ml) twice a day. The physician response to the fax identified he agreed with the facilities plan "as above." The corresponding nurses note from 12/18/24 showed staff also added liquid protein (increases healing) and notified the MD and family of the open wound areas. Interview on 2/04/25 at 1:11 p.m., with medical director (MD)-A identified he routinely received notifications from the facility by phone and fax. MD-A identified the facility had not notified him, initially, of R7's wound. Observation and interview on 02/05/25 at 09:33 a.m., with wound care nurse and nurse practitioner (NP) had removed the foam dressing on R7's right hip. R7's wound appeared red around the area the size of a dime. The surrounding skin and edges were intact had no	2 265			

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2 265	Continued From page 5 drainage from the wound. NP obtained measurements and applied a non-adhesive foam dressing and stated R7'S right hip was healed. The NP and wound care nurse had repositioned R7 to his left side. NP had removed the foam dressing on his left hip. The wound appeared as a quarter sized shape. The wound had a small slit in the wound bed with a small amount of blood draining from the wound. The edges of the wound were intact. The NP cleansed the wound, obtained measurements and applied a non-adhesive foam dressing to R7's left thigh. NP and the wound nurse discarded their supplies in the trash bin and had removed their PPE. NP and wound care nurse had sanitized their hands after leaving R7's room. NP identified R7's left hip wound was a stage 3 pressure ulcer and had improved significantly with R7's current wound treatments and wound care visits. She identified R7's left hip was to heal approximately in 1 month. NP identified R7 had cognitive deficits and appeared to lie in his bed more often since his wife had passed. She confirmed the addition of the air mattress (implemented on 12/27/24) had helped alleviate the pressures of his bilateral hips as R7 favored side lying position in bed. Interview on 2/05/25 at 3:28 p.m., with administrator identified she would expect nursing staff to follow facility policy and to notify the provider of a new onset wound needed to be assessed immediately to prevent further skin breakdown. Review of March 2024 Skin Assessment & Wound Management policy identified nursing staff were to notify the provider for treatment orders. SUGGESTED METHOD OF CORRECTION:	2 265			

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2 265	Continued From page 6 The facility should create policies or review and/or revise existing policies and procedures related to notification of change in resident health status or a change of condition. The Director of Nursing (or designee) should educate or re-educate nursing staff to those policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 265			
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day for 5 of 7 days reviewed. This had the potential to affect all 32 residents living in the facility. Findings include: Review of the nursing staff schedules and time punches for 8/29/24, 9/8/24, 9/28/24, 9/29/24 and	2 810	corrected		3/14/25

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2 810	Continued From page 7 1/11/25 identified there was no evidence an RN had worked for a minimum of 8 hours per day. Interview on 2/5/25 at 11:23 a.m., with RN-B identified the facility was short on RN coverage and either she or the director of nursing (DON) would attempt to cover those shifts as charge nurse or floor nurse, however some days no replacements could be assigned. She confirmed for the above dates, there was no RN working. Interview and document review on 2/5/25 at 12:38 p.m., with the administrator confirmed the facility failed to provide consecutive 8 hours per day of RN coverage on the above mentioned dates due to the lack of available RN staff. The facility had been attempting to recruit staff, and they also had staff hired who then quit. The administrator confirmed the facility attempted to staff according to their facility assessment, and attempted to fill those vacancies when able. A policy addressing RN coverage or staffing was requested but not provided by the end of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) should develop and/or review or revise policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per week. The DON or designee could educate staff regarding these polices, and perform measurable audit of staff schedules for compliance. The DON or designee should take the results of those audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 810			

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21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate personal protective equipment (PPE) was used during a sterile dressing change for 1 of 1 resident (R85).	21390	corrected	3/14/25	

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21390	Continued From page 9 Findings include: R85 was admitted on 1/30/25 for orthopedic aftercare with diagnoses of infection in his left hip following an arthroplasty, (a surgical procedure to replace a joint with an artificial one), absence of his left hip joint, rheumatoid arthritis, and local infection of his skin and subcutaneous tissue. 85's admission orders identified staff were to follow Enhanced Barrier Protections ((EBP), infection control (IP) control practices that use PPE to reduce the spread of multi-resistant organisms (MDROs)), while caring for IV lines and during performance of high contact personal cares. R85 had a peripherally inserted central catheter ((PICC), a flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart). through which his antibiotic medication was administered. The sterile dressing on his left upper arm, PICC line dressing was to be changed weekly with documentation placed in the progress notes. Review of R85's current, undated care plan identified he was on EBPs, due to a surgical wound on his left hip, and a PICC in his left upper arm. Interventions directed staff to wear PPE according to EBP and administer the IV medication (Ceftriaxone 2 grams (GM) every 24 hours), through 3/7/25. Staff were to monitor the PICC insertion site and report any signs of infection, discomfort, or adverse reactions.. Observation on 2/3/25 at 5:11 p.m., with registered nurse (RN)-B as she performed a sterile dressing change to R85's PICC site. A sign was posted on the outside of R85's door identifying EBP and listing the PPE to be worn for any close contact procedures. PPE to be worn	21390			

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21390	Continued From page 10 included a mask, gown and gloves. The supplies were located on a cart outside the resident room. RN-B gathered supplies to perform the sterile dressing change, entered R85's room and explained the dressing change procedure. RN-B was wearing a mask upon entering the room, washed her hands and applied gloves, but no gown. She then cleansed the surface of the bedside table with Sanicloth wipes prior to placing the dressing change items on the surface. RN-B had R85 also mask, changed gloves and performed hand hygiene appropriately. She changed the dressing and performed the indicated measurements using sterile technique. RN-B finished the procedure by flushing a new end cap, applying it to the PICC line and flushing the line with sterile saline, then dated and initialed the dressing and cleaned up her supplies. Interview on 2/3/25 at 5:45 p.m., with RN-B identified R85 was on EBP due to his surgical hip wound and PICC line. She reported EBP PPE would include a gown, gloves and mask to be worn when providing any personal care especially if there was a change for body fluid contact. RN-B identified she had not worn a gown when performing the PICC dressing change, and she was not certain why, but stated she should have. She identified she was nervous at being observed and had not though about it. Interview on 2/4/25 at 9:16 a.m., with trained medication aid (TMA)-A identified if a resident had been placed on EBP, PPE required would include a mask, gown, and gloves and that would be for any task requiring personal contact with the resident. Interview on 2/4/25 at 11:11 a.m., with TMA-B identified R85 was on EBP due to having a PICC	21390			

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21390	Continued From page 11 line and any care provided requiring contact would require use of a gown, mask and gloves. She identified there was also a sign posted on the outside of the door when a resident was on EBP and PPE was located outside the door. she reported the sign was bright colored and visible when approaching the room, because he liked to have his door closed. Interview on 2/4/25 at 11:28 a.m., with licensed practical nurse (LPN)-A identified R85 was on EBP due to a surgical wound on his left hip and he had a PICC line for administration of IV antibiotics. LPN-A reported the dressings were checked every day, but the hip dressing was not removed and the PICC line dressing was changed by the RN. Interview on 2/4/25 at 3:00 p.m., with the infection preventionist (IP) identified R85 was on EBP due to his hip infection and having a PICC line in place for antibiotic administration. She identified he had a return appointment with the infection prevention MD on Friday 2/7/25 and they would be receiving additional information following that visit. The IP identified if a resident was placed on EBP staff were to wear a gown, gloves and mask with any procedure or care requiring close contact. If there was a potential for splashing, goggles/face shield were to be added. She reported her expectation for staff to wear appropriate PPE even if they were not working specifically with the PICC line, but gave the example of assisting with bathing, transferring, or any high contact activity. Review of the current, undated Enhanced Barrier Precautions policy identified to avoid transmission of multi-drug-resistant organisms. All staff have received training on EBP at the time of hire and it	21390			

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21390	Continued From page 12 is repeated annually. Signage was to be posted on either the door or wall outside a resident's room to identify the type of precautions, what PPE was indicated, and the high-contact activities that required the use of PPE. The IP was to complete periodic monitoring to ensure compliance and provide additional training if indicated. EBP were to remain in place for the duration of the resident's stay or until a wound was healed or the medical device discontinued. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390			
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services.	21475			3/14/25

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NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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21475	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess and meet the needs of 1 of 1 (R7) resident reviewed for the provision of medically related social services, who was grieving the death of a significant other. Findings include: R7's 11/15/24, annual Minimum Data Set (MDS) identified R7 was cognitively intact and had a diagnoses of dementia, anxiety, depression, psychotic (impaired relationship with reality, confusion, hallucinations and delusions) disorder and malnutrition. R7 had little interest or pleasure in doing things and had trouble falling or staying asleep or sleeping too much 12 to 14 days. R7 had felt down, depressed, hopeless, had a poor appetite, felt bad about himself, or have let himself or his family down, had trouble concentrating on things, moving or speaking slowly that other people would not have notice, and thoughts that R7 would be better off dead or wanting to hurt himself in some way never to 1 day. R7's current, undated care plan identified R7 was at risk for alteration of mood and behavior. Staff were to provide redirection, validate R7's feelings with regards to his wife's passing, monitor side effects related to medication management, be aware of mood and behavior changes, monitor and respond to unmet needs and contact R7's family with concerns. There was no mention staff had appropriately monitored R7's behaviors or mood for his ability to cope with his wife's death. R7's 11/14/24, Target Behavior Form identified	21475	corrected		

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21475	Continued From page 14 R7's wife had passed recently and appeared sad. R7 displayed anxiety related to his wife's funeral service. R7 "appeared helpless and dependent on staff" for his care needs. R7's 11/14/24, Patient Health Questionnaire (PHQ-9) identified he was mildly depressed. R7's 11/15/24 at 1:53 p.m., progress note identified R7 was informed by the social services designee (SSD) and R7's stepson that his wife had passed. R7 wanted to be left alone and declined SSD to sit with him. There were no further notes from social services for any visits. R7's 11/22/24, progress note by physician (MD)-A identified due to R7's dementia, he may not be able to comprehend his wife had passed. R7 had behaviors and hallucinations and was to continue on his current medication management. There was no mention MD-A advised staff to frequently check his coping with his wife's passing as that may require enhanced monitoring of R7's psychosocial needs. R7's activities log identified on: 1) November 2024, R7 had refused to participate in activities 18 times, lower than normal. 2) December 2024 had refused to participate in activities 19 times, lower than normal. 3) January 2025 had refused to participate in activities 9 times but was beginning to improve with participation. Observation on 2/03/25 at 7:11 p.m., identified R7 was asleep in bed. Interview on 2/03/25 at 7:31 p.m., with trained medication aide (TMA)-A wife had passed last November. R7 and his wife had been married for	21475			

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21475	Continued From page 15 30 years. The facility had a memorial service for her with R7 in attendance. She identified R7 appeared withdrawn and did not attend daily activities he normally would and ate his meals in his room. Interview on 2/04/25 at 1:11 p.m., with medical director (MD)-A identified he would see R7 on physician rounds. Often R7 would often be asleep. MD-A noted R7 appeared sad and withdrawn after his wife's death and agreed staff should monitor R7 for his psychosocial needs and potential withdrawal and provide medically related social services. Interview on 2/04/25 at 4:42 p.m., with social services designee (SSD) identified R7 had used telehealth services in 2023 for his mental health. She was present in R7's room along with R7's family when they had informed R7 that his wife has passed. SSD identified she frequently checked in on R7, but noted she had not documented any visit. She noted she had not reviewed R7 psychosocial or behavioral needs after R7's wife had passed and residents coping with the loss of a loved one should be monitored for negative effects on thier well-being. Interview on 2/05/25 at 3:07 p.m., with licensed practical nurse (LPN)-C identified R7 was self-isolating in his room. R7 was aware his wife had passed but at the time it occurred, it appeared to have no effect on him. She identified a referral for mental health services was discussed at team meetings but they determined those would not be appropriate for R7 and stated it would "not make a difference" due to his dementia and his past medical history of electro-shock therapy.	21475			

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21475	Continued From page 16 Review of Social Service Director job description identified the designee was to provide 1:1 visit with residents to assess psychosocial needs and to provide reassurance, support of resident/families grieving, encourage family involvement and support, communicate to appropriate facility staff psychosocial needs and problems to each resident and make referrals to the community, individuals or agencies to meet residents' psychosocial needs. Interview on 2/05/25 at 3:28 p.m., with administrator had no policy related to bereavement services. She identified staff had not received direction on how to assist R7 with his grieving. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies and procedures to ensure medically related social services are provided to each resident throughout their stay and upon discharge and make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. The facility should identify other residents who are at risk for the deficient practice, review, re-educate staff to policies and procedures, and audit services to be provided by social services for a measurable amount of time. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21475			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/05/2025. At the time of this survey, River Valley Health and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/03/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. River Valley Health & Rehabilitation Center Is is a one-story building with no basement. The facility is fully fire sprinkler protected, and was determined to be of Type II(000) construction. The original building was constructed in 1962, with building additions in 1966 and 1975. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2	K 000			
K 353 SS=D	The facility has a capacity of 43 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.2, and 5.2.1.3. This deficient finding could have an isolated impact on	K 353		3/4/25	
			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 Executive Director or any employees, agents or other individuals who draft or may be discussed		

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K 353	Continued From page 3 residents within the facility. Findings include: On 02/05/2025 between 9:30 and 11:15 AM, it was revealed by observation that a sidewall sprinkler was blocked by the dining room door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	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. K353 -During the walk-through it was identified that inspection and maintenance of the automatic sprinkler system was an area for improvement. It was observed that a sidewall sprinkler was blocked by the dining room door. -Failure to meet the requirements of this regulation could have had an isolated impact on residents within the facility at the time of inspection. -Summit Fire was contacted immediately for a quote on relocation of the sprinkler head. They stated that they will be here on 3/4/2025 to do the relocation of the sprinkler head.		

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K 353	Continued From page 4	K 353			
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363	- Audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. -Audit results will be reviewed at QAPI. Areas of concern will be corrected immediately. -Maintenance Director or designee is responsible party. -Corrective action will be completed asap, upon availability of approved vendors..		3/3/25

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K 363	Continued From page 5 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 9:30 and 11:15 AM, it was revealed by observations that the door to resident room 15 was blocked open with a garbage can. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363	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 Executive Director 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		

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K 363	Continued From page 6	K 363	programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. K363 -During the walk through, it was observed that the facility failed to maintain corridor doors per NFPA 101, Life safety code, section 19.3.6.3.10, it was observed that the door To room 15 was blocked open with a Garbage can. -Per recommendation, a door mag lock was installed Immediately on door 15 to prevent the door from closing. -If this requirement is not met, the finding could have had an isolated impact on the residents within the facility. -- Audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. -Audit results will be reviewed at QAPI. Areas of concern will be corrected immediately. -Maintenance Director or designee is responsible party. -Corrective action has been completed, as of this day, 3/3/25.		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372			3/3/25

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K 372	Continued From page 7 fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 9:30 and 11:15 AM, it was revealed by observation that fire caulking was missing from around wires that were penetrating the North Smoke Barrier. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 372	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 Executive Director 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.		

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K 372	Continued From page 8	K 372	K372 -During the walk through an observation revealed that The fire caulking was missing from around the wires That were penetrating the North Smoke Barrier. -Fire caulk was immediately added around the exposed Wires to make sure the requirement was met. -If this requirement is not met, it has the potential to Have an isolated impact on the residents within the facility. - Audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. -Audit results will be reviewed at QAPI. Areas of concern will be corrected immediately. -Maintenance Director or designee is responsible party. -Corrective action has been completed, as of this day, 3/3/25.		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or	K 374			3/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER RIVER VALLEY HEALTH AND REHABILITATION CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283		
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K 374	Continued From page 9 automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/05/2025 between 9:30 and 11:15 AM, it was revealed by observation that the smoke barrier door by Room 15 did not close completely when released from the magnetic hold-open device leaving a gap at the bottom of the door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	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 Executive Director 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. K374 -During the walk thru it was observed that The smoke barrier door by Room 15 did		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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K 374	Continued From page 10	K 374	not close Completely when released from the magnetic Hold open device leaving a gap at the bottom of the Door -The door guard was removed immediately, which then Enabled the door to completely shut. -If this requirement is not met, it has the potential To have an isolated impact on the residents Within the facility. -- Audits will be completed each week for two (2) weeks; bi-weekly for four (4) weeks; and monthly thereafter for one (1) month. -Audit results will be reviewed at QAPI. Areas of concern will be corrected immediately. --Maintenance Director or designee is responsible party. -Corrective action has been completed, as of this day, 3/3/25.		