

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	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336</p> <p>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).</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R7's 11/14/24, [NAME] 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).</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of March 2024 Skin Assessment & Wound Management policy identified nursing staff were to notify the provider for treatment orders.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336</p> <p>Based on observation, interview and document review, the facility failed to ensure ventilator equipment supply water was not expired for 1 of 1 (R18).</p> <p>Findings include:</p> <p>R18's [DATE], 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.</p> <p>R18's current, undated care plan identified R18 used a ventilator for her COPD. The nursing staff 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.</p> <p>Observation and interview on [DATE] 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 [DATE]. 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 [DATE]. She confirmed the facility should be checking for expiration dates and should not use expired sterile water.</p> <p>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.</p> <p>Interview on [DATE] 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 staff.</p> <p>Interview on [DATE] 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).</p> <p>R18's [DATE], [DATE], and [DATE], 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 [DATE]. There was no indication the TAR included for staff to check the expiration on water.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] 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 [DATE] 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 change the bag once the contents were empty or if it was expired.</p> <p>Observation and interview on [DATE] at 10:12 a.m., with the administrator in R18's room identified the sterile water was expired as of [DATE]. 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.</p> <p>A policy for the ventilator machine and requested but none was provided.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>34083</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A policy addressing RN coverage or staffing was requested but not provided by the end of the survey.</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49336</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R7's 11/14/24, Patient Health Questionnaire (PHQ-9) identified he was mildly depressed.</p> <p>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.</p> <p>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.</p> <p>R7's activities log identified on:</p> <ol style="list-style-type: none"> 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. <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3) January 2025 had refused to participate in activities 9 times but was beginning to improve with participation.</p> <p>Observation on 2/03/25 at 7:11 p.m., identified R7 was asleep in bed.</p> <p>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 [AGE] 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.</p> <p>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 withdrawl and provide medically related social services.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>34083</p> <p>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.</p> <p>Findings include:</p> <p>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 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).</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>(continued on next page)</p>		

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083</p> <p>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).</p> <p>Findings include:</p> <p>R85 was admitted on [DATE] 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.</p> <p>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.</p> <p>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</p> <p>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.</p> <p>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 thought about it.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42586</p> <p>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.</p> <p>Findings include:</p> <p>R21's Minimum Data Set (MDS) dated [DATE], indicated R21 was admitted on [DATE], was currently [AGE] 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.</p> <p>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.</p> <p>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 5 years after the last pneumococcal vaccine dose.</p> <p>R21's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines.</p> <p>R31</p> <p>R31's admission Minimum Data Set (MDS) dated [DATE], indicated R31 was admitted on [DATE], was currently [AGE] 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.</p> <p>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.</p> <p>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.</p> <p>R31's medical record lacked documentation of a discussion of shared clinical decision making regarding additional pneumococcal vaccines.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p> <p>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.</p> <p>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), 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.</p>		