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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Health and Rehabilitation Center LLC	200 South Dekalb Street Redwood Falls, 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to notify the medical provider with a change in condition for 1 of 1 resident (R33) reviewed for notification of change. Finding include:R33's face sheet provided on 3/24/26, included diagnosis of heart disease. R33's admission Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, clear speech, could understand and be understood. R33 required supervision or partial assistance for most activities of daily living.R33's physician orders did not include an order for transfer to the hospital. Facility standing orders did not provide guidance for transfer to the hospital. R33's care plan did not include focus areas for heart disease or respiratory concerns.Progress notes indicated no documentation that a provider had been notified for three consecutive transports to the local emergency department (ED):--On 2/22/26 at 2:15 p.m., R33 was transported by ambulance to the ED for bilateral lung crackles, wheezing and shortness of breath. Family member (FM)-A had been in attendance at the facility. Registered nurse (RN)-A who was also the nurse manager, had been notified. At 5:58 p.m., staff at the hospital called the facility to report R33 would be returning.--On 2/23/26 at 7:20 p.m., R33 was transported by ambulance to the ED for hoarse voice, phlegm crackling in throat, hard time clearing throat, diminished lung sounds and wheezing. FM-A had been called and updated, as well as facility on-call nurse. At 10:00 p.m., R33 returned to the facility. --On 2/24/26 at 8:39 a.m., R33 was transported by ambulance to the ED due to audible crackles in lungs and low oxygen saturation. FM-A had been notified. At 10:21 a.m., the hospital called the facility to inform staff R33 would be admitted for acute respiratory failure. On 3/11/26 at 2:58 p.m., R33 returned to the facility. During an interview on 3/24/26 at 11:42 a.m., the director of nursing (DON) stated a provider would not necessarily be notified when a resident's condition changed requiring transfer to the ED. The DON stated R33 had frequent condition changes and his family had been notified. Requested change in condition policy, undated, which indicated facility staff made appropriate notification to the physician when there was a change in condition; changes in condition were reported to the physician. During an interview on 3/24/26 at 12:06 p.m., licensed practical nurse (LPN)-A stated when a resident's condition changed and needed to go to the hospital, nursing staff called the facility nurse on-call and/or DON, family member, and faxed the provider. In the fax, LPN-A stated the provider would be informed of what was going on with the resident and when the resident was sent to the hospital. LPN-A stated this was done all hours - days, evenings and nights. LPN-A stated she didn't know who received the fax or when it was reviewed. LPN-A stated nursing staff would not call a provider to notify them of a residents change in condition or to ask for guidance prior to sending to the hospital, adding, We just send them - we don't wait - so they get the care they need.During an interview on 3/24/26 at 12:29 p.m., the DON was asked what the facility policy on change in condition directed staff to do when a resident's condition changed. The DON stated the policy was to inform the provider and should be done real time, as the change was occurring. During an interview on 3/24/26 at 12:45 p.m., the DON reviewed the progress notes for the dates R33 had been transferred to the ED and stated a provider should have been contacted before anyone else had been notified. The DON acknowledged in some cases a provider who had knowledge (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of a resident might recommend medication or treatment first, and transport to the hospital might not be necessary. Facility Notification of Changes policy, undated, indicated it was the policy of the facility that changes in a resident's condition or treatment would be shared with the resident and/or resident representative according to their authority, and reported to the attending physician or delegate. Nurses and other care staff were educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure the best outcomes of care for the resident. The objective of the policy was to ensure that facility staff made appropriate notification to the physician and notification to the resident and/or resident representative when there was a change in the resident's condition. The intent of the policy was to provide appropriate and timely information to the parties who will make decisions about care, treatment and preferences to address the changes.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to accurately code the presence of a pressure ulcer on the admission Minimum Data Set (MDS) assessment for 1 of 3 residents (R20) reviewed for pressure ulcers. Findings Include: R20's admission Minimum Data Set (MDS) dated [DATE], indicated R20 was admitted to the facility on [DATE], no cognitive impairment, required supervision with personal hygiene, and dependent with dressing, toileting, and transfers; diagnosis included pressure ulcer of sacral region unspecified stage, and Section M-Skin Conditions indicated R20 had no unhealed pressure ulcers/injuries. R20's Interim Payment Assessment MDS dated [DATE], indicated one or more unhealed pressure ulcers, and one stage 3 pressure ulcer. R20's care plan dated 1/19/26, indicated pressure injury to buttocks and interventions included; Monitor skin integrity daily during cares, .weekly skin inspection by nurse , treatment to open areas per order. R20's hospital summary report dated 1/15/26, indicated .sacral wound was identified as the likely source of infection and pressure injury of skin of sacral region. R20's Admission/Initial Data Collection assessment dated [DATE], indicated wound on coccyx area measuring 4.5 cm (centimeter) x 1 cm. On 3/23/2026 at 4:10 p.m. R20 stated she had a pressure ulcer upon admission from a previous facility located on her buttocks. On 3/24/2026 at 10:50 a.m., licensed practical nurse (LPN)-A stated she was the current MDS nurse but did not complete R20's 1/22/26 MDS. LPN-A stated registered nurse (RN)-B completed the assessment remotely and confirmed the admission MDS should have reflected a pressure ulcer. On 3/24/2026 at 1:00 p.m., during a telephone interview RN-B stated they were a MDS nurse and completed R20's MDS dated [DATE], section M and marked no for pressure ulcer but acknowledged this was an error. RN-B stated the skin assessment indicated a pressure ulcer but failed to correctly code it as a pressure ulcer on the MDS, impacting evaluation and treatment coding.On 3/24/2026 at 1:10 p.m., during a telephone interview RN-C stated they were the MDS specialist and assisted with MDS training and education and confirmed R20's wound should have been coded as a pressure ulcer and confirmed it was miscoded. RN-C stated that accurate coding is necessary to develop the care plan and guide treatments and that staff are expected to follow the RAI (Resident Assessment Instrument) Manual.On 3/24/2026 at 1:33 p.m., the director of nursing (DON) stated expectations were that MDS assessments are accurate. On 3/24/26 at 2:02 p.m., the administrator indicated in an email that the facility does not have a specific MDS policy and relies on compliance with the RAI Manual for coding and accuracy.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow ordered wound care treatments, failed to ensure availability and use of ordered supplies, and failed to notify the provider when treatments were not completed for a pressure-related wound for 1 of 3 residents (R10) reviewed for pressure ulcers. Findings include: R10's discharge assessment - return anticipated Minimum Data Set (MDS) dated [DATE], indicated no cognitive impairment, required substantial/maximal assistance with personal hygiene, dependent on assistance with transfers, utilized a wheelchair, diagnoses included sepsis, burn of third degree on the buttock; unhealed pressure ulcers/injuries, one stage 3 pressure ulcer that was present upon admission/entry or reentry. R10's entry tracking MDS dated [DATE], indicated on 3/16/26, R10 was readmitted from a short-term general hospital. R10's care plan revision dated 3/17/26, indicated pressure ulceration to R (right) buttock and R dorsum foot and interventions included treatment to open areas per order. R10's inpatient hospital wound care note dated 3/11/26, nurse practitioner (NP)-C indicated new today is a wound present on the dorsum of his right foot. This appears to be related to pressure.R10's wound care follow up progress note dated 3/18/26, NP-C indicated ulceration on the right anterior foot after debridement measures 1 cm (centimeter) x 1.1 cm x 0.1 cm, 100% slough covered. To the ulceration present on the anterior right foot, lodosorb (used to clean wounds and promote healing of skin ulcers and wounds) was placed to the wound bed then Aquacel Ag Hydroftber (dressing absorbs fluid and bacteria from the wound and creates a moist environment that promotes healing) and protected with Mepilex silicone-based foam dressing. Change dressings every 3 days or if 50% saturated or greater, soiled or rolled edges that cannot be smoothed. Ulceration dorsum, right foot: 3. Wash hands, apply gloves, remove dressings, clean wound with 4 x 4 gauze soaked in wound cleanser 4. Apply lodosorb to the wound bed then cover with Aquacel Ag Hydrofiber 5. Cover with a Mepilex silicone-based foam dressing, can reinforce with tape as needed6. Change dressing every 3 days or if 50% saturated or greater, soiled or rolled edges that cannot be smoothed.R10's treatment administration record (TAR) dated 3/1/26-3/31/26, indicated start date 3/21/26, ulceration dorsum of R foot: 1) Gently cleanse w/ wound cleanser and gauze 2) Apply lodosorb to areas of slough and cover w/ Aquacel AG hydrofiber (calcium alginate) 3) Cover w/ adhesive foam dressing. every day shift every 3 day(s) for Ulceration Change PRN if greater than 50% saturated, edges rolled or missing. On 3/21/26, and 3/24/26, the TAR had a check mark with staff initials indicating the treatment was complete. On 3/23/26 at 1:32 p.m., R10 stated he had pressure areas on his foot, stated the area was improving, and confirmed staff were performing dressing changes and repositioning.On 3/24/26 at 8:27 a.m., licensed practical nurse (LPN)-A stated she had completed R10's dressing change on his foot that morning and the ordered lodosorb was unavailable. LPN-A stated she applied Aquacel and a foam dressing without the Iodosorb and had not notified the provider, wound care team, or registered nurse (RN)-A (facility nurse manager and wound care nurse) at that time. LPN-A stated the dressing change was ordered every three days and as needed. LPN-A further stated when R10 was readmitted to the facility after hospitalization, the right foot ulcer was present.On 3/24/26 at 2:31 p.m., LPN-A was observed entering the time clock room and stated she had completed her shift. LPN-A confirmed she had forgotten to contact the provider regarding unavailable supplies for R10's dressing change. LPN-A stated she would go back to contact the provider; however, she indicated the provider was not in the office and would be rounding the following day. LPN-A stated she planned to leave a note for the provider to address the dressing change but had not checked whether lodosorb had been ordered.On 3/24/26 at 3:11 p.m., the director of nursing (DON) stated staff are expected to follow physician orders, and if supplies are unavailable, an equivalent may be used, with documentation of what was completed and notification to the provider.On 3/24/26 at 3:55 p.m., RN-A, the facility wound care nurse, stated the facility utilizes an outside wound provider who evaluates residents (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	approximately every two weeks. RN-A stated the provider assessed R10 on 3/18/26 and issued new wound care orders. RN-A further stated the wound care provider would have left necessary supplies, including Iodosorb, at the facility for staff use. RN-A stated if Iodosorb was not available, staff were expected to contact the pharmacy to reorder the product or contact the provider or wound clinic for an alternative treatment.On 3/24/26 at 4:05 p.m., observation of R10's room with RN-A revealed Iodosorb was located in R10's room.On 3/24/26 at 4:26 p.m., during a telephone interview NP-C stated they had ongoing concerns and discrepancies between ordered and completed treatments of wounds at the facility. NP-C stated Iodosorb was necessary for debridement and prevention of further wound breakdown and infection. NP-C stated prior communication had occurred with the DON regarding concerns with wound care practices and that staff should notify the provider if treatments cannot be completed as ordered. NP-C stated they would have expected a phone call today when the dressing change could not be completed as ordered. On 3/24/26 at 4:31 p.m., the DON stated expectations were that physician orders should be followed but acknowledged prior instances of incorrect dressing application. The DON further stated NP-C had not raised concerns regarding incorrect supplies not being used, and the only concern previously discussed was a dressing was not fully secured and had shifted from the intended area of coverage. The DON confirmed some education had been provided to nursing staff regarding dressing changes but could not recall when or the specifics.On 3/24/26 at 6:16 p.m., RN-A was observed completing R10's dressing change to the right dorsum of the foot. Upon removal of the existing dressing, RN-A confirmed there was no evidence of Iodosorb present. RN-A stated the dressing would have appeared orange in color if the Iodosorb was used. RN-A then completed the dressing change in accordance with NP-C's orders.The facility Skin Assessment & Wound Management Policy dated 2/25, indicatedOngoing Skin Issues- Follow ongoing treatments per provider order.- Update provider and resident/representative as needed.- Update care plan as needed

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to administer a physician-ordered medication for 1 of 1 resident (R37), when lorazepam (used to treat anxiety) was not administered. The facility did not notify the provider or leadership, or implement an alternative intervention, resulting in a medication omission for several days. Findings include:R37's face sheet provided on 3/24/26, included diagnoses of congestive heart failure (when heart muscles cannot pump enough blood to meet the body's needs) and generalized anxiety. R37's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R37 was either independent or needed partial assistance for most activities of daily living and was independent with walking. R37's handwritten physician order dated 12/12/25, (no time listed) indicated to start lorazepam 0.25 mg (milligram), 7:00 a.m. and 7:00 p.m. R37's care plan dated 11/10/24, indicated R37 was at risk for alteration in comfort and would have adequate pain relief. During record review, R37 had been experiencing anxiety for which lorazepam had been ordered on 12/12/25. Despite the order, R37 had not received the medication until 12/15/25. Progress note dated 12/12/25 at 2:48 p.m., indicated R37 has been seen by medical doctor (MD)-D. R37 had been more anxious due to shortness of breath and MD-D ordered to start lorazepam. Orders were faxed to pharmacy.Progress notes for the lorazepam subsequently indicated the following: -- Friday 12/12/25 at 2:48 p.m., orders faxed to pharmacy.-- Friday, 12/12/25 at 8:23 p.m., medication not available.-- Saturday, 12/13/25 at 11:15 p.m., pharmacy yet to deliver medication. -- Sunday, 12/14/25 at 12:13 p.m., medication will be delivered from pharmacy today.-- Sunday, 12/14/25 at 8:52 p.m., medication not available. -- Sunday 12/14/25, according to pharmacy, lorazepam had been delivered to the facility at 11:00 p.m.-- Monday, 12/15/25 at 8:09 a.m., registered nurse (RN)-A who was also the nurse manager indicated in a progress note, that written orders had been received from MD-D on 12/12/25, for lorazepam 0.25 mg, however the medication with instructions received from pharmacy indicated the dose to be lorazepam 0.5 mg. RN-A contacted pharmacy and was informed the reason was because the e-prescription from MD-D indicated a dosage of 0.5 mg. RN-A reached out to the clinic to obtain clarification of dosage from MD-D, but no response was received. -- Monday 12/15/25 at 9:34 a.m., still needing clarification on dose.-- Monday 12/15/25 at 11:23 a.m., progress note by RN-A indicated she attempted to reach MD-D, but when no answer, sent an urgent fax.-- Monday 12/15/25 at 2:44 p.m., progress note by licensed practical nurse (LPN)-A indicated family member (FM)-B and FM-C had questioned why R37 had not received lorazepam when it had been ordered on 12/12/25. LPN-A informed them the lorazepam order needed clarification on the dosage as the facility and pharmacy had different orders. FM-B questioned why that had not been handled on Friday or over the weekend. LPN-A explained to FM-B nursing was working on it. FM-B stated R37 should not have to ask for anything, should just get the lorazepam. R37 rated her pain 3/10 and denied needing additional pain medication. FM-C stated to LPN-A this should not have happened and R37 should have had her medication right away on Friday - She's [AGE] years old; she should be living her best life. FM-B told LPN-A she was told over the weekend that the medications would be handled and straightened out but I just keep getting lied too. LPN-A informed both FM-B and FM-C she would speak with the social worker and DON (director of nursing) regarding their complaints. -- Tuesday 12/16/25 at 4:01 p.m., progress note indicated MD-D's nurse was contacted about the continued discrepancy in doses for lorazepam (0.25 mg vs 0.5 mg). Requested MD-D's nurse to ask MD-D for an updated order regarding which dose to administer. -- Tuesday 12/16/25 at 7:00 p.m., per the medication administration record (MAR), the first dose of lorazepam was documented as being administered. During an interview on 3/24/26 at 4:29 p.m., RN-A recalled R37 and reviewed her progress notes in the electronic medical record from 12/12/25 to 12/15/25. RN-A stated there had been a discrepancy in the order for lorazepam dosages between what the facility received from the physician and what the pharmacy received from the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN-A stated she had first been aware of the concern of R37 not receiving lorazepam over the weekend when she arrived to work on 12/15/25. RN-A didn't know if staff on duty over the weekend had attempted to contact a provider to clarify the order, or if they contacted leadership, such as the DON to assist with problem-solving.During an interview on 3/24/26 at 5:18 p.m., with the DON and administrator, both stated they had not been aware of the medication discrepancy and subsequent failure to administer a physician-ordered medication. The DON who was on-call that weekend, did not remember if he had received a call from nursing staff. The DON stated he would have expected staff to notify the provider and him, and acknowledged lorazepam was important to R37 who had just started on hospice and who experienced anxiety related to shortness of breath.During a telephone interview on 3/24/26 at 6:09 p.m., FM-C expressed concern about R37 not receiving lorazepam in a timely manner after it had been ordered by the physician. FM-C couldn't understand why staff were not able to resolve the problem with the order over the weekend (weekend of 12/12/25). FM-C stated once R37 did receive the lorazepam, it took the edge off the pain and anxiety, and she was able to die with dignity. On 3/24/26 at 6:15 p.m., and 6:35 p.m., attempted to reach nursing staff who had worked the weekend of 12/12/25, and who had documented progress notes about lorazepam not being available, but did not receive a return call as of 3/25/26.During an interview on 3/25/26 at 1:15 p.m., customer service representative at Polaris Pharmacy stated an original order from the facility had been received on 12/12/25, but was not a valid prescription because it did not include a provider signature, quantity of medication, or DEA (drug enforcement administration) number which were required for controlled medications. A blank e-script was then routed to the ordering provider, MD-D, to inform him. On 12/13/25, at 10 p.m., an e-prescription was received from MD-D for lorazepam 0.5 mg by mouth in the morning and one tablet 0.5 mg in the evening. Maximum daily dose 1 mg. Quantity 60 tablets. Since it was after delivery time, the medication had not been delivered. According to the representative, on 12/14/25 at 11:00 p.m., the lorazepam had been delivered to the facility for R37. Facility Medication and Treatment Orders policy dated 2/2024, indicated order for medications would be consistent with principles of safe and effective order writing. Orders must include name and strength of the drug; number of doses, start and stop date, and/or specific duration of therapy; dosage and frequency of administration; route of administration; clinical condition or symptoms for which the medication is prescribed. Only authorized personnel shall call in orders for prescribed medications to the pharmacy.