STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Renvilla Health Center	205 Southeast Elm Avenue Renville, MN 56284

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to notify the physician of new wounds for 1 of 3 residents (R1) reviewed for pressure ulcers and impaired skin integrity. Findings include:R1's face sheet identified diagnoses of non-ST elevation myocardial infarction (heart attack from blockage of artery), chronic atrial fibrillation (heart flutter), cellulitis (bacterial infection) of left lower limb, type 2 diabetes, stage 5 chronic kidney disease dependent on renal dialysis, left below knee amputation, and cardiomyopathy (heart disease). R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 did not have cognitive impairment, no behaviors, but would reject evaluation or care four to six days. R1 required maximum to complete assistance with activities of daily living. R1 had one stage two pressure ulcer on admission (right lateral foot). R1's facility admission skin/wound assessment dated [DATE], identified fourteen wounds. One of the fourteen wounds assessed identified a blister to right dorsum 4th digit toe, not applicable to stage, present on admission. Measured 4.1 cm x 3.3 cm with depth, undermining, tunnelling marked as not applicable. Wound bed had granulation tissue but was unmarked how much of the wound was filled, no evidence of infection, moderate serous exudate, attached edges, surrounding tissue was excoriated and normal temperature, no edema, induration, or pain. Dressing was intact and non-adherent synthetic.R1's signed physician orders dated 10/7/25, identified wound care orders for four of the fourteen wounds identified on admission. These orders were for the wounds identified at the hospital and treated at the hospital and did not include orders for the right 4th toe.During a phone interview on 10/22/25 at 12:56 p.m., registered nurse (RN)-B stated he was the admission nurse for R1 when he came to the facility on [DATE]. R1 arrived at the facility from the hospital with wound care that was being done for a bunch of wounds. On admission, R1's toes on his right foot were covered in a dressing. RN-B removed the dressing and the toes were macerated with drainage around them and built up between the toes. The three middle toes, on the tops of them had drainage from those wounds, and a reddish color around the wounds. The dressing change for the toes was done on the same schedule as the heel dressing. RN-B could not recall what the order was for the toes but thought it was silver alginate and cover with gauze. RN-B stated he put the orders for R1 in the computer. RN-B did not notify the physician of the wounds.During an interview on 10/22/25 at 1:15 p.m., licensed practical nurse (LPN)-B stated during the night on 10/8/25, the kerlix wrapped around the toes had fallen off. There was no order in the medication administration record (MAR) for a dressing change, but she reapplied the wrap as they were. During a phone interview on 10/22/25 a 2:56 p.m., LPN-A stated on 10/11/25, R1's third and fourth toes were near black with a thick, white drainage coming from between the toes and the pinkie toe was gray. LPN-A was unable to separate the toes and cleaned the drainage as best as she could. LPN-A did not notify the physician of the wounds or the appearance of them as she assumed the physician was already aware of them. 10/16/25, LPN-A worked and stated she did not look at or do wound care on his toes as the physician had seen R1 and LPN-A thought the physician did the wound care on them.During a phone interview on 10/23/25 at 9:53 a.m., R1's primary care physician (PCP)-A stated she saw R1 on 10/16/25. PCP-A did not evaluate or look at R1's toes as they were wrapped and done by wound care. PCP-A did not recall receiving any information from the facility about wounds on R1 since his admission.During an interview on 10/24/25 at 9:47 a.m., Administrator stated it was an expectation that all areas on the body that have a dressing on them have a corresponding treatment plan in place and the physician notified. It is also an expectation that staff follow standing orders for new wound treatments, include the order in the resident MAR, notify physician, include interventions in care plan, and complete skin/wound assessment.The facility policy titled Skin Integrity dated 5/21/25, identified care center staff will notify the licensed nurse when a new skin integrity issue is observed. Licensed nurse will: assess the area and identify the cause, remove any source of pressure or trauma to the area, clean the area and provide treatment per House Standing Orders, complete a skin incident report in residents electronic health record, notify resident/responsible party, notify provider and request treatment orders, notify nurse manager/wound nurse, initiate a new tissue tolerance, initiate appropriate preventative measures based on the immediate root cause.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to incorporate skin integrity interventions into care plans for 2 of 3 residents (R1, R2) who were reviewed for skin.Findings include: R1's face sheet identified diagnoses of non-ST elevation myocardial infarction (heart attack from blockage of artery), chronic atrial fibrillation (heart flutter), cellulitis (bacterial infection) of left lower limb, type 2 diabetes, stage 5 chronic kidney disease dependent on renal dialysis, left below knee amputation, cardiomyopathy (heart disease), sleep apnea, and hypertension.R1's admission Minimum Data Set (MDS) dated [DATE], identified no cognitive deficits, no behaviors, but would reject evaluation or care four to six days. R1 required maximum to complete assistance with activities of daily living. R1 had one stage two pressure ulcer on admission (right lateral foot). Care Area Assessment (CAA) triggered pressure ulcer, care planning decision dated 10/20/25.R1's facility admission skin/wound assessment dated [DATE], identified fourteen wounds.R1's care plan dated 10/8/25, identified R1 was on enhanced barrier precautions (EBP) related to pressure sores.Review of R1's care plan did not identify wounds, wound care, or interventions to prevent deterioration of skin integrity.R2R2's face sheet dated 10/22/25, identified diagnoses of non-pressure chronic ulcer of unspecified part of right lower leg, non-pressure chronic ulcer of unspecified part of left lower leg, varicose veins of left lower extremity with ulcer of unspecified site, stage 3 pressure ulcer of left heel, and localized edema.R2's admission MDS dated [DATE], identified R1 had some cognitive deficits, required assistance with activities of daily living, had pressure injuries and was at risk to develop pressure injuries.R2's care plan dated 10/22/25, identified impairment to skin integrity upon admission included venous stasis ulcers on bilateral lower extremities, pressure ulcer on left heel, pressure ulcer on right heel healed on 10/21/25. Interventions included air mattress, encourage good nutrition and hydration, float heels in bed, turn and reposition every 2.5 hours to prevent skin breakdown, treatment per provider orders, seen weekly by wound care nurse, weekly treatment documentation to include measurement of each area of skin breakdowns width, length, depth, type of tissue and exudate, and any other notable changes or observations.R2's Kardex for nursing assistants dated 10/22/25, identified enhanced barrier precautions (EBP), and air mattress on bed.R2's physician orders dated 9/30/25, identified an order for heel protectors to bilateral heels.R2's physician wound care orders dated 10/1/25, identified treatment recommendations of heel protectors to bilateral heels.R2's physician wound care orders dated 10/7/25, identified treatment recommendations of heel protectors to bilateral heels. R2's physician wound care orders dated 10/14/25, identified treatment recommendations of heel protectors to bilateral heels.R2's physician wound care orders dated 10/21/25, identified treatment recommendations of heel protectors to bilateral heels.R2's progress note dated 10/11/25, identified dressing was not intact to left heel and had moved completely away from the heel. Heel boots were not in place due to drainage and odor. Pillows were placed.During a phone interview on 10/23/25 at 2:29 p.m., RN-D stated the facility charting needs to improve. Management is working on care planning and getting a plan for improvement with them. During an interview on 10/24/25 at 9:47 a.m., administrator stated all interventions for prevention of skin breakdown, wound management, and wounds should be included in the care plan.The facility Person Centered Care Planning policy dated 12/18/23, identified each residents care plan will include measurable objectives and timeframes to meet a residents medical, nursing, mental, and psychosocial needs identified through the residents comprehensive assessment. The plan of care will describe: services that are to be furnished to attain or maintain the residents highest practicable wellbeing, management of risk factors and prevent avoidable declines in function

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate, monitor, and notify the physician of wounds for 1 of 1 resident (R1) who was assessed on admission to have multiple wounds reviewed for impaired skin integrity. Findings include:R1's face sheet identified diagnoses of non-ST elevation myocardial infarction (heart attack from blockage of artery), chronic atrial fibrillation (heart flutter), cellulitis (bacterial infection) of left lower limb, type 2 diabetes, stage 5 chronic kidney disease dependent on renal dialysis, left below knee amputation, and cardiomyopathy (heart disease). R1's hospital Discharge summary dated [DATE], identified six skin issues on discharge but did not identify skin injury to right 4th toe. Wounds identified included: 1. Full thickness wound due to infection/edema of left residual limb2. Full thickness wound to right leg (edema)3. Right ear (unclear)4. Right arm/back/neck (trauma)5. Non-pressure open wounds due to perforating dermatitis of right anterior leg and left ear6. Partial thickness wound due to friction/shear of buttocks, pressure ulcer buttocksR1's admission Minimum Data Set (MDS) dated [DATE], identified no cognitive deficits, no behaviors, but would reject evaluation or care four to six days. R1 required maximum to complete assistance with activities of daily living. R1 had one stage two pressure ulcer on admission (right lateral foot). Care Area Assessment (CAA) triggered pressure ulcer, care planning decision dated 10/20/25.R1's skin and wound evaluation dated 10/7/25, identified blister to right dorsum 4th digit toe, not applicable to stage, present on admission. Measured 4.1 cm x 3.3 cm with depth, undermining, tunnelling marked as not applicable. Wound bed had granulation tissue but was unmarked how much of the wound was filled, no evidence of infection, moderate serous exudate, attached edges, surrounding tissue was excoriated and normal temperature, no edema, induration, or pain. Dressing was intact and non-adherent synthetic. Included in the admission skin/wound assessment were the following:1. Front right knee abrasion 1.4x1.8x1.3cm light exudate attached edges; dressing intact foam2. Blister right dorsum 4th digit toe 4.5x4.1x3.3cm granulation wound bed; moderate exudate serous, excoriated surrounding tissue; dressing intact non-adherent synthetic3. Right shin abrasion 2.2x2.4x1.3cm; granulation wound bed; foam dressing intact4. Stage 2 pressure ulcer right lateral foot 0.9x 1.4x0.9 no depth; wound bed is epithelial no dressing applied5. Left below knee amputation (BKA) site 9.6 x 4.2 x 3.0; wound bed granulation; light exudate serous; foam dressing intact6. Abrasion left BKA amputation site proximal no measurements; granulation wound bed, light exudate; foam dressing intact7. Abrasion patella 4.3x4.7x1.7; scab no drainage foam dressing intact8. Left antecubital space abrasion 1.1 x 1.5 x 1.0; scab; fragile skin at risk for breakdown; no dressing9. Left inner forearm bruise not measured10. Left antecubital space bruise 29.5x9.8x4.611. Right shoulder abrasion not measured no dressing12. Upper outer right arm abrasion not measured no dressing13. Right scapula abrasion not measured no dressing14. Sacrococcygeal open lesion 2.3x3.8x2.0; light serous exudate foam dressing intact Review of R1's signed physician orders dated 10/7/25, did not identify orders for wound care treatment to right 4th digit toe R1's care plan dated 10/8/25, identified R1 was on enhanced barrier precautions due to pressure sores. Review of R1's care plan did not identify specified wound locations, treatments, or interventions identified on the care plan R1's progress note dated 10/11/25 at 12:59 a.m., R1's toes were dark purple in appears and stuck to the kerlix and it took some time to remove the old dressing. At 1:55 p.m., identified R1 had purulent (thick, milky discharge, often signals infection) drainage coming from the right third, fourth, and fifth toes that was covered with telfa (nonadherent dressing) and kerlix (gauze bandage). R1's progress note dated 10/12/25 at 11:43 p.m., identified right foot redressed as it was draining outside of the dressing. The note did not identify what treatment was applied. R1's emergency room discharge date d 10/13/25, identified open wounds to left anterior toes with discoloration noted to the toes, positive dorsalis pedis (top of foot by big toe) pulse and able to move toes. X-ray of right foot showed extensive vascular calcifications (calcium salts in walls of blood vessels), no osteomyelitis (bone infection), skin ulceration noted along the plantar aspect deep to the calcaneus (bottom of foot to heel). discharged to facility with scheduled Tylenol for pain and recommendations for wound care. Iodosorb (iodine) gel 0.9% apply topically as needed for wound care to reduce germ load was listed as patient not taking and reported on 10/10/25 from an order on 10/7/25. R1's progress note dated 10/13/25 at 11:55 p.m., identified R1 returned from ED with new orders to change wound dressings daily and change small pads between right toes daily.R1's skin and wound evaluation dated 10/14/25, identified a blister to front right lateral lower leg that was acquired at facility. Wound measured 7.1 cm x 1.3 cm. The evaluation did not include any further characteristics of the wound

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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 record review the facility failed to identify and comprehensively assess a pressure ulcer for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include:R3's face sheet dated 10/22/25, identified diagnoses of fracture of lower end of right femur, type 2 diabetes.R3's admission Minimum Data Set (MDS) dated [DATE], identified no cognition issue, refused cares four to six days a week, substantial assistance with activities of daily living, always incontinent of bowel and bladder, and had no skin conditions.R3's care plan dated 7/10/25, identified impairment to skin integrity. Interventions included to encourage good nutrition and hydration to promote healthier skin, and skin treatments per provider, update as needed. Check all of body for breaks in skin and treat promptly.R3's Braden scale dated 7/30/25, identified a score of 15, which is at risk for skin impairment.R3's skin and wound evaluation dated 10/21/25, did not identify an open area to R3's coccyx.R3's progress note dated 10/21/25 at 7:53 p.m., identified R3 had a bed bath, see skin and wound note for details. During an observation and interview on 10/22/25 at 10:00 a.m., R3 was in bed and nursing assistants (NA)-A and NA-B were assisting R3 with dressing and pericares. While NA-B turned R3 on her left side R3 was observed to have an open spot on her coccyx with some fresh blood noted. R3 stated nurse knows about the spot, she was in here last night and did not think it was bad enough to need photos taken. NA-B applied barrier cream to coccyx. R3 did not want the nurse called to the room to look at the area as she was leaving for an appointment.During an observation and interview on 10/23/25 at 9:18 a.m., R3 was in bed. licensed practical nurse (LPN-A) stated she was not aware that R3 had a reddened area on her coccyx. R3 stated it is red, not opened. LPN-A informed R3 the area was open. LPN-A measured the area as 0.5 cm x 0.5 cm. LPN-A stated a wound should have a picture taken of it, and the wound covered with Vaseline then a bordered foam dressing applied. An order for a dressing change should be in the computer, and the wound should be assessed on bath days. NA's would look at the wound daily with peri cares. R3's progress note dated 10/23/25 at 10:15 a.m., identified LPN-A was alerted for a reddened spot on coccyx. Upon evaluation, there was a 0.5 centimeters (cm) by (x) 0.5 cm open area. No pain, not bleeding, no drainage. R3 requested to only treat with barrier cream and no bandage. During an interview on 10/23/25 at 2:57 p.m., NA-A stated R3's wound was there yesterday. NA-A indicated when it was reported to the nurse, the nurse was dismissive and walked awayDuring a phone interview on 10/23/25 at 3:18 p.m., registered nurse (RN)-D stated the facility has not had a lot of wounds, and they are working towards improvements with wound care. The expectation of floor nurses was to not stage wounds, notify director of nursing, and wound nurse of skin impairment and have one of them stage the wound for accuracy.During an interview on 10/24/25 at 9:47 a.m., Administrator stated management staff reviews all pressure sores in risk management weekly.The facility Skin Integrity policy dated 11/26/24, identified nursing staff will monitor residents skin integrity and address issues promptly while providing care and services consistent with professional standards of practice.