STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375141	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Skilled Nursing and Therapy	2400 West Modelle Clinton, OK 73601

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 record review and interview, the facility failed to notify the physician of severe weight loss defined as greater than 5% in 30 days, greater than 7.5% in 90 days, and greater than 10% in 180 days for 1 (#7) of 2 sampled residents reviewed for significant weight loss.The administrator identified two residents had significant weight loss within 90 days. Findings: A policy titled Weight List, dated 10/21/09, read in part, The resident's physician should be notified of any significant weight changes. An admission assessment for Resident #7, dated 02/22/26, showed the resident was admitted to the facility on [DATE] with diagnoses which included a left hip fracture and parkinsonism. The assessment showed Resident #7 weighed 193 pounds. A nutrition progress note for Resident #7, dated 03/12/26, showed the resident was seen by the dietician and was found to have had significant weight loss. The progress note stated to alert the physician of significant weight loss. An undated weight log for Resident #7 showed on 03/16/26 the resident weighed 157.6 pounds. Resident #7 had an 18.34% weight loss from admission. A review of Resident #7's health chart showed no notifications to the physician regarding significant weight loss between 02/16/26 and 03/16/26. On 03/18/26 at 10:07 a.m., CMA #1 stated the certified nurse aides or CMAs obtained resident weights. They stated they overlooked the weight loss for Resident #7 and did not report it to the charge nurse. On 03/18/26 at 10:12 a.m., the DON stated they monitored resident weights monthly and reported gain or loss to the physician. The DON reviewed Resident #7's weight log and stated the physician had not been notified of their significant weight loss.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed to address reoccurring pneumonia for 1 (#4) of 14 sampled resident's reviewed for care plans.The administrator identified 55 residents resided in the facility.Findings:A physician's order for Resident #4, dated 08/01/25, showed the resident was on Levaquin (fluoroquinolone antibiotic), two times a day for seven days for pneumonia. A physician order for Resident #4, dated 12/29/25, showed the resident was on Doxycycline (tetracycline antibiotic), two times a day for pneumonia. A physician's order for Resident #4, dated 03/12/26, showed the resident was on Doxycycline for a lower respiratory tract infection for seven days. A review of Resident #4's health record and revised care plan did not show any interventions for preventing or treating recurring pneumonia.On 03/18/26 at 11:25 a.m., the DON stated resident did not come out of their room. The DON stated the interventions for treating pneumonia for Resident #4 were per physician's orders. They stated there were no interventions to prevent recurring pneumonia.On 03/18/26 at 1:18 p.m., the MDS coordinator stated there was no care plan for prevention or treatment of Resident #4's pneumonia. They stated active and recurring pneumonia should have been included in the care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control precautions were used during indwelling catheter care for 1 (#1) of 3 sampled residents reviewed for infection control practicesThe administrator identified eight residents had indwelling catheters requiring infection control precautions during care. Findings:On 03/18/26 at 1:33 p.m., LPN #1 was observed to don a gown and gloves and place the front of incontinent brief flat on the bed between Resident #1's legs. LPN #1 was observed to begin performing indwelling catheter care for Resident #1. LPN #1 was observed to secure the tabs on the incontinent brief once it was back in place while wearing the same soiled gloves. LPN #1 was observed to adjust the bed covers on Resident #1 and returned the overbed table beside the bed without removing their gloves. LPN #1 was observed to pick up Resident #1's water pitcher and place it within their reach on the table, still wearing the same gloves used to provide indwelling catheter care. LPN #1 was observed to not change gloves during catheter care.A facility document titled Catheter Care Guideline, dated 03/2025, read in part, Our facility is committed to providing proper catheter care in accordance with current professional standards of practice. And to ensure care aligns with safe effective management of urinary catheters and reduce risk of infection and promote resident comfort and dignity. An admitting physician order for Resident #1, dated 01/2026, showed the resident was admitted to facility on 01/02/26 with diagnoses which included urinary retention, benign prostate hyperplasia, and stage 2 pressure ulcer of sacral region. A 5-day MDS assessment for Resident #1, dated 01/04/26, showed the resident had a brief interview for mental status score of 15 indicating intact cognition. The assessment showed Resident #1 required assistance with bowel incontinence and indwelling catheter care. A care plan for Resident #1, initiated 01/04/26, showed the resident had an indwelling catheter and required enhanced barrier precautions.On 03/18/26 at 1:39 p.m., LPN #1 stated they felt like everything was done correctly while performing catheter care on Resident #1. On 03/19/26 at 10:00 a.m., the DON stated there was no skills check sheet to evaluate correct procedures for catheter care. The DON verified LPN #1 should have changed gloves.