STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165376	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Valley Nursing and Rehabilitation	17990 Spencer Road Pleasant Valley, IA 52767

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on a record review, staff and family interviews, and a policy review, the facility failed to refund an overpayment within 30 days after 1 of 1 residents passed away at the facility (Resident #5). The facility reported a census of 37 residents. Findings include:Resident #5's admission Record documented an admission date of 1/24/24 and a discharge date of 11/12/25.Review of a Check Request dated 11/20/25 documented that $6,840 dollars belonged as a refund to Resident #5's trust account. Resident #5 maintained a payor source of private pay and paid in full for the month but passed away prior to the end of the month.Review of Resident #5's Statement for December 2025 documented a surplus of $6,840.00 in the facility's account.Review of Resident #5's Statement for January 2026 documented a surplus of $6,840.00 in the facility's account.Review of Resident #5's Statement for February 2026 documented a surplus of $6,840.00 in the facility's account.Review of Resident #5's Statement for March 2026 documented a surplus of $6,840.00 in the facility's account.Review of Resident #5's Statement for April 2026 documented a surplus of $6,840.00 in the facility's account.Review of Resident #5's Statement for May 2026 documented a surplus of $6,840.00 in the facility's account.On 6/3/26 at 1:10 PM, Resident #5's Power of Attorney (POA) revealed the facility called her today and informed her they worked on refunding the money and planned to mail it out to her. She revealed Resident #5 passed away in November and she received nothing since. She originally gave the facility a couple months to refund the overpayment, then started calling them, and eventually went to the facility to personally try talking with them. Staff told her the person who handled the refunds lacked presence at the facility at that time. She tried to contact the business manager, who acted quite rude on the phone and hung up on her. The facility failed to contact her. She sent a certified letter in February, but heard nothing, so she reported the matter to the state, and the facility randomly called her today.On 6/8/26 at 4:45 PM, the Administrator revealed the [NAME] President of Operations (VPO) with the facility's management company lacked awareness that he needed to approve the request before the facility could refund the money.Review of the facility's administrative policy, last revised March 2021, titled Conveyance of Resident Funds, instructed the facility that the resident's personal funds and a final accounting of funds are to be returned to the resident, the resident's representative, or to the resident's estate, as applicable, within thirty days from the date of the resident's discharge, eviction from the facility, or death.

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interview, the facility failed to develop and implement a discharge planning process, including identifying discharge goal, preferences and necessary referrals to assist 1 of 2 residents (Resident #2) who expressed a desire to leave the facility. The facility reported a census of 37 residents. Findings include:Review of Resident #2's Minimum Data Set (MDS) dated [DATE], reviewed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The list of diagnoses included diabetes, Parkinsonism (a group of neurological disorders that cause motor symptoms like slowed movement, muscle stiffness, tremors, and balance issues), non-Alzheimer's dementia and schizophrenia. The MDS indicated Resident #2 utilized a walker and wheelchair, required partial/moderate assistance to walk and shower/bathe, and substantial/maximal assistance for toileting hygiene. On 6/2/26 at 3:05 PM, Resident #2 overhead telling staff he just wants to leave and go somewhere else.Review of the Resident #2's Care Plan revealed a Focus area to address I wish to remain in this facility long term due to my medical condition. Initiated: 9/16/25. Interventions included:a. Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear, distress. Initiated. 9/16/25.b. Evaluate the resident's motivation to return to the community. Initiated. 9/16/25.The Care Plan did not include Focus areas or Interventions to address the residents request to leave and go somewhere else. During an interview on 6/4/26 at 12:05 PM, the Administrator on 6/4/26 stated she is going to send out referrals today for Resident #2 to go to a smoking facility.Via an email exchanged n 6/8/26 at 1:17 PM, the Director of Nursing (DON) stated four referrals have been sent out for Resident #2.During an interview on 6/9/26 at 10:23 AM, Resident #2 stated no one has talked to him about discharging.During an interview on 6/9/26 at 10:25 AM, Social Services staff stated she wasn't aware of any referrals made for Resident #2 during his current stay to discharge. She explained she might've sent a referral 2 months ago to a facility but they refused to accept the resident. The Social Service staff stated Resident #3 had not mentioned wanting to leave the facility. She added the only conversation she typically has with the resident is about his finances.During an interview on 6/9/26 at 10:41 AM, the Administrator stated she and the Social Services staff discussed discharging with Resident #2. He informed them that he spoke with the prior administrator about him discharging to another facility.During an interview on 6/10/26 at 12:59 PM, the facility Advanced Registered Nurse Practitioner (ARNP) stated Resident #2 just wants to leave, he brought it up a couple of months ago, and the facility did referrals, she was unaware of the outcome. During an interview on 6/10/26 at 1:34 PM, Staff H, Certified Medication Assistant (CMA) stated Resident #2 wants to go somewhere else because he wants to smoke more. Staff H stated Resident #2 started saying he wanted to leave about a month ago, and Staff H told the prior Administrator.During an interview on 6/10/26 at 2:21 PM, the DON stated Resident #2 shouts out that he wants to get out of the facility and go somewhere else, and he has done that since admission. The DON stated that today another facility communicated that they might take Resident #2.During an interview on 6/10/26 at 3:32 PM, the Administrator sdtated she was never told Resident #2 wanted to be discharged . The Administrator stated that facility staff members sent out referrals when the matter was brought to her attention last week, and they sent referrals to smoking facilities.Review of the facility policy Resident Rights revised October 2025 directed that residents have multiple rights while living at the facility including but not limited to: communication with and access to people and services, both inside and outside the facility; self-determination; exercise their rights without interference, coercion, discrimination, or reprisal from the facility; and be informed of, and participate in, their care planning and treatment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff and resident interviews, and a policy review, the facility failed to implement Restorative care to assist a resident in maintaining his highest practical level of walking for 1 of 1 resident (Resident #2) reviewed for restorative care. The facility reported a census of 37 residents. Findings include: 1. Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The list of diagnoses included diabetes, Parkinsonism (a group of neurological disorders that cause motor symptoms like slowed movement, muscle stiffness, tremors, and balance issues). The MDS indicated Resident #2 utilized a walker and wheelchair, and required partial/moderate assistance to walk 10 feet, 50 feet with two turns and 150 feet. Review of Occupational Therapy Discharge summary dated [DATE] revealed Resident #2 received services from 1/19/26 to 4/8/26, and discharged due to highest practical level achieved. The summary documented the ambulated 160 feet with partial assistance. Discharge recommendations included: 24-hour care, Shower chair with back, Assistance with ADL's, Assistance device for safe functional mobility, Grab bars, Home exercise program.Review of the electronic health record (EHR) revealed the following:a. A Health Status Note entered on 4/16/26 at 2:45 PM: New Order - Restorative care, daily PT would like to walk daily. b. A Health Status Note entered on 4/17/26 at 10:47 AM by the Director of Nursing (DON): Order not needed as this is nursing judgement. Will discuss with nursing department and therapy. Review of Resident #2's Care Plan revealed the following Focus areas:a. I require assistance with ADL's r/t (related to) impaired balance. Initiated: 9/15/25. Interventions included, in part:1. PT/OT evaluation and treatment per MD orders. initiated: 9/15/25.b. I am at risk for falls r/t Gait/balance problems, incontinence, Psychoactive drug use. Initiated: 9/15/25. Interventions included, in part, all initiated on 9/15/25:1. I ambulate with assist of 1 gait belt and walker. Initiated2. Anticipate and meet the resident's needs;3. Encourage the resident to participate in activities that promote exercise, physical active for strengthening and improved mobility.A Focus area to address the specific need for Restorative program not included in the Care Plan.During an interview on 6/1/26 at 3:10 PM, Resident #2 stated that staff don't walk him. He stated they're supposed to walk him every day. The resident stated now he can't walk, and then added he probably can. During a second interview on 6/2/26 at 3:05 PM, Resident #2 stated that he last walked when therapy worked with him. He revealed that staff members won't walk him, and he just wants to leave the facility and go somewhere else.During an interview on 6/9/26 at 3:14 PM, Staff N, Occupational Therapist (OT) stated Resident #2 enjoyed walking. Staff N stated that therapy staff is expected to get individuals to their highest functional level, and then afterwards facility staff take over and maintains that level. Staff N stated sometimes that includes a restorative program or walking program.During an interview on 6/9/26 at 3:30 PM, Staff O, Certified Occupational Therapy Assistant stated Resident #2 has a history of stating that facility staff members did not walk him when he was receiving services. Staff O stated that staff members chart this information in a binder, and the Minimum Data Set (MDS) Coordinator works remotely to review it. Staff O believed that Resident #2's restorative program included bilateral lower extremity (both legs) strengthening and walking for 15 minutes six to seven times a week.During an interview on 6/9/26 at 4:08 PM, Staff A, Licensed Practical Nurse (LPN) stated Resident #2 can transfer in and out of bed but does not walk. Staff A stated that Resident #2 does not have a restorative program.During an interview on 6/10/26 at 12:59 PM, the facility Advanced Registered Nurse Practitioner (ARNP) stated Resident #2 asked for a walking program, and the ARNP stated that if Resident #2 wanted it, the program should still be going.During an interview on 6/10/26 at 2:00 PM, Staff L, Certified Nursing Assistant (CNA) stated she manages scheduling and Restorative Care. Staff L stated Resident #2 does not have a Restorative Program, and is not on the Restorative list. Staff L (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she never heard of doing a walking program with Resident #2 and did not see an order for a walking program in April 2026. Staff L noted that if an order exists, it should go straight to the MDS Coordinator.During an interview on 6/10/26 at 2:21 PM, the DON stated the MDS Coordinator leads the Restorative program. The DON stated that the MDS Coordinator told the prior administrator she was no longer doing the program, which has been the case for maybe a month. The DON stated Resident #2 is not on a Restorative program, though staff members try to get him to walk now and then. The DON stated Resident #2 did not need a restorative program per nursing judgement because he probably would not do it.During an interview on 6/10/26 at 3:03 PM, the MDS Coordinator stated she does not believe Resident #2 is on a Restorative program, though did he receive Occupational Therapy a while back. The MDS Coordinator stated she never got updated on Resident #2 needing therapy and noted that nursing would have received the form since she is not in the building. The MDS Coordinator stated she goes into the building once a week, performs assessments for a couple of hours, and then leaves.Review of a facility policy titled Restorative Nursing Services, revised July 2017 included a a Policy Statement which declared: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The Policy Interpretation and Implementation section directed, in part:1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies).3. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.4. The resident or representative will be included in determining goals and the plan of care.