STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165615	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Valley Living and Rehab	400 Sergeant Square Drive Sergeant Bluff, IA 51054

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 3 of 5 residents (Residents #8, #32, and #35) reviewed. The facility reported a census of 48 residents.Findings include:1. Review of Resident #8's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. Interview on 2/23/26 at 11:48 AM with Resident #8 revealed that she often eats in her room, and the food when it is delivered is often cold and not hot. Resident #8 then revealed that the food does taste good, but the food is just cold when it comes on the trays as it sits longer before it is delivered. 2. Review of Resident #32's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. Interview on 2/23/26 at 12:25 PM with Resident #32 revealed that she prefers to eat in her room, and when the food is delivered she is lucky if it is even room temperature. Resident #32 further revealed that several of her meals have been delivered cold. Observation 2/24/26 at 12:50 PM a tray was obtained for a temperature check. Temperatures at that time were 109.2 for the hot ham and cheese sandwich, 125.2 for the green beans, french fries were 101.1, and mandarin oranges were 46.8 degrees. Interview 2/24/26 at 12:50 PM with the Dietary Manager revealed that she would like to see the mandarin oranges be a little colder, but she gets that these trays went down the hallways for delivery. Another observation on 2/25/26 at 1:06 PM another sample tray was obtained and temperatures were obtained with the caramelized butternut squash being 118.4, and the mixed vegetables being 120.9 degrees. A follow up interview 2/25/26 at 1:20 PM with the Dietary Manager revealed that food temps should be served at the appropriate temperatures. 3. Review of Resident #35's MDS dated [DATE] revealed a BIMS of 15 indicating intact cognitive functioning. In an interview on 2/23/26 at 12:42 PM, Resident #35 reported the food is cold most of the time. In an interview on 2/25/26 at 2:17 PM, Resident #35 reported that she ate meals in the dining room. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked about today's meals, the resident stated, It was cold like most of the time. When asked to clarify what was meant by most of the time, the resident responded, Most of the days, most of the meals. The Food Preparation Area policy last revised in November 2010 included Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Cooking and Holding Temperatures and Times The danger zone for food temperatures is between 41 degrees and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained at 40 degrees or below or at 136 degrees or above. Potentially hazardous foods held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause foodborne illness. The following internal cooking temperatures/times for specific foods must be reached to kill or sufficiently inactivate pathogenic microorganisms: Poultry and stuffed foods - 165 degrees F, Ground meat, ground fish and eggs held for service - at least 115 degrees F, Fish and other meats - 145 degrees F for 15 seconds, Fresh, frozen or canned fruits/vegetables - 135 degrees F.

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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 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. The facility failed to properly complete the Centers of Medicare & Medicaid form #10055 for 3 of 3 sampled residents. (Residents #4, #8 and #54). The facility reported a census of 48 residents.Findings Include: 1. The ABN form #10055 dated 1/26/26 for Resident #4 revealed the form lacked the reason Medicare may not pay and the estimated cost of services. 2. The ABN form #10055 dated 8/5/25 for Resident #8 revealed the form lacked the estimated cost of skilled nursing care. 3.The ABN form #10055 dated 10/2/25 for Resident #54 revealed the form lacked the estimated cost of skilled nursing care. The Medicare Advanced Beneficiary Notice policy Dated April 2021 identified if the admissions coordinator or business office manager believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee-for-Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). The facility issues the Skilled Nursing Facility Advanced Beneficiary Notice (CMS form 10055) to the resident prior to providing care that Medicare usually covers, but may not pay for because the care is considered not medically reasonable and necessary, or custodial. The resident (or representative) may choose to continue receiving the skilled services that may not becovered, and assume financial responsibility. The Centers for Medicare and Medicaid Beneficiary Notices website (https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN), last modified on 12/01/2021 at 8:00 PM, provided the link to the undated document titled Form Instructions Advance Beneficiary Notice of Non-coverage that provided instruction for ABN estimated cost of services. The form instructed that notifiers must complete the column under Blank (F) to ensure the beneficiary has all available information to make an informed decision about whether or not to obtain potentially non-covered services. Notifiers must make a good faith effort to insert a reasonable estimate for all of the items or services listed under Blank (D). In general, we would expect that the estimate should be within $100 or 25% of the actual costs, whichever is greater; however, an estimate that exceeds the actual cost substantially would generally still be acceptable, since the beneficiary would not be harmed if the actual costs were less than predicted. Multiple items or services that are routinely grouped can be bundled into a single cost estimate. For example, a single cost estimate can be given for a group of laboratory tests, such as a basic metabolic panel (BMP). An average daily cost estimate is also permissible for long term or complex projections. As noted above, providers may also pre-print a menu of items or services in the column under Blank (D) and include a cost estimate alongside each item or service. If a situation involves the possibility of additional tests or procedures (such as in laboratory reflex testing), and the costs associated with such tests cannot be reasonably estimated by the notifier at the time of ABN delivery, the notifier may enter the initial cost estimate and indicate the possibility of further testing. Finally, if for some reason the notifier is unable to provide a good faith estimate of projected costs at the time of ABN delivery, the notifier may indicate in the cost estimate area that no cost estimate is available. We would not expect either of these last two scenarios to be routine or frequent practices, but the beneficiary would have the option of signing the ABN and accepting liability in these situations. In an interview on 2/25/25 at 2:54 PM, the Administrator reported that the approximate cost of services is required to be completed on ABN form #10055. The Administrator further stated, I have reviewed other forms, and it's filled out. I don't know how those were missed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to refer 1 resident with a negative Level I result for the Preadmission Screening and Resident Review (PASARR), who was later identified with newly evident or possible serious mental disorder, intellectual disability, or other related condition, to the appropriate state-designated authority for Level II PASARR evaluation and determination for 1 out of 2 residents (Resident #14) reviewed for PASARR requirements. The facility reported a census of 48 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #14 documented diagnoses of anemia, heart failure and agitation and restlessness. The MDS included a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. Review of note to attending physician or prescriber from the pharmacy dated 2/17/26 requesting diagnosis that best fits the patient with the usage of antipsychotic drugs returned with an x in front of delusional disorder signed by the physician and dated 2/20/26 and noted by the facility on 2/23/26. Review of the Progress Note dated 2/23/26 at 11:21 a.m., entered by the Director of Nursing (DON) revealed the following:Received signed return pharmacy communication about olanzapine (antipsychotic medication) 5 milligram (mg) daily. Asking for a diagnosis that fits the resident. Primary care physician responds with F22, Delusional Disorder. Diagnosis list updated, Medication Administration Record (MAR) updated and filed in chart. Review of current medical diagnosis revealed a diagnosis for delusional disorders with a created date of 2/23/26. Review of the PASARR dated 1/30/26 lacked inclusion of delusional disorder diagnosis. The clinical record lacked an updated PASARR to include delusional disorder diagnosis. The facility does not have a policy on PASARR procedures. Interview on 3/2/2026 at 3:07 p.m., with the DON revealed the diagnosis should be listed on the PASARR and she would submit a new one.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview the facility failed to revise and update care plans to include hospice care for 1 out of 12 residents reviewed (Resident #6). The facility reported a census of 48 residents. Findings included: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented diagnoses of heart failure, diabetes mellitus and hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Interview on 02/23/2026 at 11:25 a.m., with Resident #6 revealed she had been started on hospice care recently to help with pain control. Review of Resident #6's Progress Notes revealed the following information:On 2/16/25 at 9:20 a.m., resident's power of attorney (POA) visited with this worker and stated that he would like a hospice consult. He elected hospice of his choice. Spoke with chosen hospice and they stated they will contact POA to discuss services. On 2/16/25 at 4:01 p.m., Hospice visited with resident, she is interested in services if qualifies, hospice reached out to primary care physician, she was going to send orders, no orders received, call placed to to office, verbal order for ok for hospice to evaluate and treat if appropriate. Order received and noted, hospice may be out today for intake. On 2/17/25 at 12:31 p.m., received signed order for ok for hospice to evaluate and treat. Filed in chart. On 2/19/26 at 8:05 p.m., resident remains on hospice. On 2/22/25 at 8:22 p.m., resident remains on hospice. Review of the care plan with a revised date 2/25/26 lacked information on hospice services and hospice care choice. Review of facility provided policy titled Care Planning-Interdisciplinary reviewed April 2016 revealed our facility's care planning interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment and is developed by a care planning interdisciplinary team which may include facility staff, therapy staff, contracted staff, hospice staff, physicians, ect. Interview on 3/2/2026 at 3:09 p.m., with the Director of Nursing (DON) revealed hospice care should be listed on the face sheet when you open the electronic chart and should be on the care plan. Interview on 03/03/2026 at 8:46 a.m., with the MDS coordinator revealed she normally would have put the agency and this one got missed. She is working on developing an area for hospice to add to the care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review the facility failed to notify the physician after resident refused ordered daily weights or were not completed for 1 of 1 residents reviewed (Resident #6) for daily weights. The facility reported a census of 48 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #6 documented diagnoses of heart failure, diabetes mellitus and hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the Order Summary Report signed and dated by the physician on 1/29/26 revealed an order for daily weight. Give as needed (PRN) Bumetanide and notify the physician for weight gain of 2-3 pounds (lbs) a day or 5lbs a week with an order date of 5/7/25 and start date of 5/8/25. Review of the January 2026 Medication Administration Record revealed the following information:1/1/26-1/2/26- marked with an x and noted drug refused1/7/26- marked as NA1/15/26- marked with an x and noted drug refused1/22/26- marked with an x and noted drug refused1/24/26- marked with an x and noted drug refused1/26/26- marked with an x and noted drug refused Review of the February 2026 Medication Administration Record revealed the following information:2/5/26- marked as NA2/11/26- marked with an x and noted drug refused 2/13/26-2/14/26- marked with an x and noted drug refused2/15/26- marked as NA 2/16/26-2/17/26- marked with and x and noted drug refused2/18/26- marked as NA2/19/26- 2/23/26- marked with an x and noted drug refused2/24/26- marked as NA 2/25/26-2/28/26- marked with an x and noted drug refused Review of the March 2026 Medication Administration Record revealed the following information:3/1/26-3/2/26- marked with an x and noted drug refused. Review of the clinical record lacked notification to the physician regarding refusal of daily weights. The facility does not have a policy that addresses notifying the physician. Interview on 3/3/2026 at 8:55 a.m., with the Assistant Director of Nursing (ADON) revealed there is no documentation of notification to the physician regarding Resident #6 refusing her daily weights or weights not being completed. The ADON expects staff to be notifying the physician if the orders are not being completed.

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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, clinical record review, facility policy review and staff interview the facility failed to complete skin assessments, notify the physician in a timely manner regarding a new pressure area to the coccyx area to ensure resident received necessary treatments, interventions and supplements to properly prevent a stage 2 pressure ulcer consistent with professional standards of practice for 1 of 1 residents reviewed (Resident #3). The facility reported a census of 48 residents.Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include:Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of Alzheimer's Disease, diabetes mellitus and hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. Review of Progress Notes revealed the following:On 12/30/25 at 5:27a.m., resident has a small open area to the base of the tail bone measuring 1.5x0.5 cm. Cream applied, doctor notified. Will continue to monitor. On 1/19/26 at 8:32 a.m., received return fax, signed by provided, re: open area to tailbone. New order received: apply house camo every shift and as needed then discontinue when healed. On 2/13/26 at 1:43 p.m., received a signed order for 2 Cal 80cc three times a day to promote wound healing and poor intakes. Medication Administration Record (MAR) updated and filed in chart. Review of resident's care plan with a revision date of 2/9/26 revealed the following:Pressure ulcer stage 2 to coccyx with a revision date of 2/9/26 Administer treatment per physician order with a revision date of 7/7/25 Assist with incontinence briefs and perineal care times 1 with a revision date of 3/7/25 Keep skin clean and dry as possible with a created date of 10/4/22 Monitor skin condition with daily dressing and weekly bathing with a created date of 10/4/22 Pressure reduction pommel cushion to recliner with a revision date of 3/7/25 Pressure reduction to wheelchair with a revision date of 3/7/25 Pressure reduction winged mattress to bed with revision date of 3/7/25 Assist as needed with a revision date of 8/23/24 Report any reddened or open areas with a created date of 10/4/22 Trial of tilt space wheelchair for positioning with a created date of 2/9/26 Treatment per MAR to pressure ulcer with a created date of 2/9/26 Review of Braden Scale assessment (tool used to evaluate risk of development of a pressure ulcer) revealed:On 5/7/25- which revealed a score of 17 indicated at risk for development of pressure sores. On 7/29/25- which revealed a score of 14 indicated a moderate risk for development pressure sores. On 11/18/25- which revealed a score of 14 indicated a moderate risk for development pressure sores. On 2/19/26- which revealed a score of 14 indicated a moderate risk for development pressure sores. Review of the weekly skin observation tool revealed the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following:On 12/18/25- no new skin issues noted at this time. On 12/25/25- lacked documentation of assessment being completed. On 1/1/26- site- coccyx, type- pressure, 0.5 centimeters (cm) length x 0.5 cm width. Doctor notified. On 1/8/25- lacked documentation of assessment being completed. On 1/15/26- resident noted to have redness on coccyx. On 1/22/26- resident has a small open area on coccyx. Measures 0.5x1. Camo applied per order. On 1/29/26- resident noted to have open area to coccyx measuring 0.1x0.1. On 2/5/26- resident noted to have open area to coccyx measuring 0.1x0.1. On 2/12/26- resident noted to have open area to coccyx measuring 0.1x0.1 On 2/19/26- resident noted to have open sore to coccyx measuring 0.3x0.3. On 2/26/26- resident noted to have open area to coccyx measuring 0.1x0.1. On 3/2/26- site- coccyx, type, pressure, length 0.5, width 0.4, stage 2. Pressure to coccyx measure 0.5x0.4cm with healing light pink tissue. Review of the Treatment Administration Record (TAR) for January 2026 revealed an order with a start date of 1/19/26 for each shift for open area on tailbone: apply house camo every shift and as needed discontinue when healed every shift for wound. The clinical record lacked documentation of any treatment of the open area to the coccyx from 12/30/25-1/19/26. Observation on 3/3/2026 at 10:17 a.m., revealed an open area to the residents coccyx area. Review of facility provided policy titled Pressure Injury Surveillance dated 2025 revealed the following: A system of surveillance is utilized for preventing, identifying, reporting and investigating any new or worsen pressure injuries in the facility. All pressure injuries will be tracked Interview on 3/2/2026 at 3:08 p.m., with the Director of Nursing (DON) revealed the skin sheets should have been completed and they were being audited by the prior Assistant Director of Nursing (ADON). She should have been aware they were not completed and she should have known about the area. The DON revealed there is no documentation between 12/30/25 and 1/19/26 with the physician regarding the wound or treatments being completed during that time.