

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 200 South Eighth Avenue East Newton, IA 50208	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on electronic health record review (EHR) and staff interviews, the facility failed to maintain complete and readily accessible resident medical records for 7 of 7 residents reviewed. The EHR failed to provide Iowa Statutory Power of Attorney (POA) documentation for these residents that indicated having an appointed POA. The facility reported a census of 61 residents. Findings include: Review of Resident #1, #4, #5, #6, #7, #8, #9's EHR indicated each resident having designated POA. Review of these records failed to provide the Iowa Statutory POA documentation for review. During an interview on 11/24/25 at 1:50 PM, Staff A, Social Services, reviewed resident's records and acknowledged Resident #1, #4, #5, #6, #7, #8, and #9's EHR and facility paper chart, failed to provide the legal documentation identifying Resident's appointed POA. In an interview on 11/24/25 at 2:50 PM, Staff A, Social Services and Staff B, Director of Nursing (DON), acknowledged the failure to provide POA documentation in resident #1, #4, #5, #6, #7, #8, and #9's records. Staff B, DON stated the facility's plan of correction will include audits of all resident's records of POA documentation (for those residents who have designated POAs), a hard copy of this document would be placed in the resident's paper chart, a copy uploaded to resident's EHR and Staff A, Social Services would also have a binder in her office with copies of the documents.		

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on Resident's Electronic Record Review (EHR), staff interview, review of CMS-2567 reports (Federal Statement of Deficiencies), and facility policy review, the facility failed to ensure an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies, resulting in a repeat deficiency identified on the facility's current complaint survey. The facility reported a census of 61 residents. Findings include: Review of Resident #1, #4, #5, #6, #7, #8, #9's EHR indicated each resident having designated POA. Review of these records failed to provide the Iowa Statutory POA documentation for review. During an interview on 11/24/25 at 1:50 PM, Staff A, Social Services, reviewed resident's records and acknowledged Resident #1, #4, #5, #6, #7, #8, and #9's EHR and facility paper chart, failed to provide the legal documentation identifying Resident's appointed POA. Review of facility's CMS-2567 Recertification report dated 8/14/25, revealed the facility had a deficiency due to the facility failing to maintain complete and readily accessible resident medical records for 2 of 3 residents reviewed during this survey. In an interview on 11/24/25 at 2:50 PM, Staff A, Social Services and Staff B, Director of Nursing (DON), both acknowledged the failure to provide complete and readily accessible medical records to include POA documentation in resident #1, #4, #5, #6, #7, #8, and #9's records. Staff B, DON stated the facility's plan of correction will include audits of all resident's records of POA documentation (for those residents who have indicated have a designated POA), a hard copy of this document would be placed in the resident's paper chart, a copy uploaded to resident's EHR, and Staff A, Social Services, would also have a binder in her office with copies of the documents.		