STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165427	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vista for Nursing and Rehabilitation	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure 2 of 2 residents reviewed for abuse were free from unreasonable confinement(Resident #7) and sexual exploitation(Resident #3). The facility reported a census of 62 residents.Findings: 1. The Minimum Data Set(MDS)assessment tool, dated 12/11/25, listed diagnoses for Resident #7 which included cerebral palsy(a disorder caused by brain abnormalities and characterized by symptoms including difficulty with movement, muscle tone, and balance), severe intellectual disabilities, and a history of healed traumatic fractures. The MDS stated the resident was dependent on staff for toileting and dressing, required partial to moderate assistance for transfers, and did not walk during the review period. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. A 12/8/25 Care Plan entry stated Resident #7 liked to spend time in the common area watching tv, listening to music, and people watching. A 12/10/25 Care Plan entry stated Resident #7 had impaired cognitive function and was able to make basic needs known through body language and saying yeah or nah. The February 2026 Documentation Survey Report V2 documented on 2/21/26 during the day shift(6:00 a.m. to 2:00 p.m.), Staff A Certified Nursing Assistant(CNA) provided the resident with assistance including the following activities of daily living: chair to bed transfers, dressing, oral hygiene, personal hygiene, and toilet transfers.On 2/24/26 at 3:42 p.m., Staff E CNA stated that last Saturday(2/21/26) Resident #7 made vocalizations and Staff A CNA placed him in his room and closed the door so she wouldn't have to hear him. She stated she reported this to Staff F Registered Nurse(RN). Staff E stated the resident didn't like being in his room and he was in there 45 minutes to 1 hour. In a follow-up interview on 2/24/26 at 3:49 p.m., Staff E stated that the resident's roommate was also present in the room at the time this happened. On 2/25/26 at 8:14 a.m., Resident #8, resident #7's roommate, stated at times, Resident #7 wanted out of the room and staff shut the door. He stated resident #7 liked to be in the common area.The Quarterly MDS dated [DATE] Resident #8 had a BIMS score of 13 out of 15, which indicated intact cognitive skills.On 2/25/26 at 10:54 a.m., Staff F, Registered Nurse(RN) stated Resident #7 did not like to be in his room. He liked sitting by the nursing station people watching. She stated staff were aware of what he wanted because he would grunt and point. At first, Staff F stated she was not aware of any staff members who placed the resident in his room when he wanted out. Upon further questioning, Staff F stated Staff E(CNA) reported to her that Staff A(CNA) placed the resident in his room and closed the door. She stated Staff E told her that Resident #7's roommate alerted the call light. Staff E stated that Staff A entered the room and asked the resident what was wrong and he pointed at the door like he wanted to go out. Staff E stated Staff A told the resident that she would be back in a minute and closed the door. Staff F stated she was not sure what day Staff E reported this to her but it was in the last week. Staff F stated she did not feel that this incident occurred on the day Staff (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E reported it to her, but a couple weeks prior. She stated she reported this to the Director of Nursing(DON) in passing. She stated her expectation was for staff to bring the resident out of his room if this was his wish. On 2/25/26 at 11:32 a.m., Staff A(CNA) denied that she closed the door and would not allow the resident out of his room. She stated she was able to determine some of the resident's wishes per his gestures. For example, the resident made a driving motion when he wanted to go somewhere and also pointed and made noises. She stated this last weekend, she did not think she took care of him as she wasn't assigned to his hall. On 2/25/26 at 11:40 a.m., the DON stated she would want staff to report it if someone placed a resident in their room and closed the door against their wishes. She stated no one reported anything of this nature to her. She stated Resident #7 loved to be out in the common area. She stated if someone notified her of this, she would have suspended the staff member while the investigation was pending. On 2/25/26 at 11:50 a.m., the Administrator stated staff should report allegations of abuse to her or the DON. She stated she would separate (the alleged perpetrator) from residents to make sure they were safe. She stated she would complete an investigation and report the allegation to the State Agency. The Administrator stated no one reported to her any concerns related to Staff A. She stated Resident #7 preferred to be out in the common area and agreed that if he gestured that he wanted out of his room, staff should honor his wishes. She stated she would suspend Staff A. 2. The MDS assessment tool, dated 11/6/25, listed diagnoses for Resident #3 which included non-Alzheimer's dementia, anxiety disorder, and depression. The MDS listed the resident's BIMS score as 8 out of 15, indicating moderately impaired cognition. 1/30/25 Care Plan entries stated the resident had an alteration in neurological status related to altered mental status and directed staff to anticipate and meet his needs. An undated 5 Day Summary Staff to Resident form stated on 12/25/25, Staff B Registered Nurse(RN) witnessed Staff C, [NAME] kiss Resident #3 on his lips while holding his hand.The facility Abuse Policy, dated June 2023, stated residents had the right to be free from abuse and to be treated with respect and dignity. The policy defined abuse to include involuntary seclusion and exploitation. The facility would report abuse to the State Agency within 2 hours and complete a timely and thorough investigation. The policy did not specifically address how the facility would protect residents during the investigation. On 2/24/26 at 9:17 a.m. the DON stated that Staff C, [NAME] was friends with Resident #3 for a long time. She stated at times, Staff C would encourage the resident to change his clothes as he was reluctant to do so. At this time, she would tug on his shirt and encourage him to change it. The DON demonstrated that Staff C would gently tug on the resident's shirt while encouraging him to change it. She stated a staff member reported that she saw Staff C kiss the resident. The DON stated that this allegation was out of character for Staff C and it didn't make any sense. She stated that the resident asked about Staff C after the facility suspended her and that he called Staff C nicest when referring to her. She stated the resident denied that Staff C kissed him during the visit. On 2/24/26 at 10:21 a.m., via phone, Staff B, Registered stated she entered the resident's room to give him his medication and there was a female visitor in his room with a child around the age of 11. She stated the female visitor and the resident were standing in front of the resident's night stand and the female visitor kissed the resident twice on the mouth. She stated the visitor had both of her hands around the resident's waist at the time of the kiss and they separated when she walked in the room. She stated she heard the resident ask the visitor to leave. She stated later, she observed the resident and the visitor walk down the hall holding hands. Staff B stated she did not know that the visitor was a staff member(Staff C Cook) until she assisted her out the front door and the visitor mentioned she worked there. Staff B stated no one else was in the room at the time of the kiss except the resident, the female visitor, and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the child who accompanied her. Staff B stated she could not tell from her vantage point whether it was a closed or open mouthed kiss. Later, she heard from an agency nurse that Staff B wanted to take another resident(Resident #10) out overnight but they did not permit this because they did not have permission from the resident's guardian. On 2/24/26 at 10:47 a.m., the Administrator stated Staff B reported to her the concern with Staff C. The Administrator stated Staff B reported that she observed Staff C kiss Resident #3 twice. When the Administrator spoke to the resident, he stated there was no inappropriate touching/kissing and it was no big deal. The resident did report that Staff C told him to take this off while he gestured to his shirt. At the time he said this, the Administrator stated she had no context to the statement. She determined later that Staff C knew the resident prior to his admission to the facility and at times encouraged him to change his shirt. The Administrator stated Staff D agency Licensed Practical Nurse(LPN) reported Staff C also wanted to check out another resident overnight. Staff C asked for the resident's medications so she could do so. Staff did not allow this as they could not get permission for the resident's guardian. The Administrator stated she thought this was inappropriate and there were boundary issues with Staff C and that she had poor judgement.On 2/24/26 at 11:25 a.m., Staff D, Licensed Practical Nurse(LPN) stated on Christmas Day there was a kitchen staff member(Staff C) who wanted to take a resident out of the facility overnight and requested his medications. Staff D stated she did not allow this as she did not have permission from the resident's guardian. She stated she did not observe Staff C kiss or touch any residents. On 2/25/26 at 2:28 p.m., the Administrator stated staff should treat residents with kindness and they should be free from abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to report an allegation of abuse to the State Agency for 1 of 2 residents reviewed for abuse(Resident #7). The facility reported a census of 62 residents.Findings: 1. The Minimum Data Set(MDS)assessment tool, dated 12/11/25, listed diagnoses for Resident #7 which included cerebral palsy(a disorder caused by brain abnormalities and characterized by symptoms including difficulty with movement, muscle tone, and balance), severe intellectual disabilities, and a history of healed traumatic fractures. The MDS stated the resident was dependent on staff for toileting and dressing, required partial to moderate assistance for transfers, and did not walk during the review period. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The facility Abuse Policy, dated June 2023, stated residents had the right to be free from abuse and to be treated with respect and dignity. The policy defined abuse to include involuntary seclusion. The facility would report abuse to the State Agency within 2 hours and complete a timely and thorough investigation. A 12/8/25 Care Plan entry stated Resident #7 liked to spend time in the common area watching tv, listening to music, and people watching. A 12/10/25 Care Plan entry stated Resident #7 had impaired cognitive function and was able to make basic needs known through body language and saying yeah or nah. The February 2026 Documentation Survey Report V2 documented on 2/21/26 during the day shift(6:00 a.m. to 2:00 p.m.), Staff A Certified Nursing Assistant(CNA) provided the resident with assistance including the following activities of daily living: chair to bed transfers, dressing, oral hygiene, personal hygiene, and toilet transfers.On 2/24/26 at 3:42 p.m., Staff E CNA stated that last Saturday(2/21/26) Resident #7 made vocalizations and Staff A CNA placed him in his room and closed the door so she wouldn't have to hear him. She stated she reported this to Staff F Registered Nurse(RN). Staff E stated the resident didn't like being in his room and he was in there 45 minutes to 1 hour. In a follow-up interview on 2/24/26 at 3:49 p.m., Staff E stated that the resident's roommate was also present in the room at the time this happened. On 2/25/26 at 8:14 a.m., Resident #8, resident #7's roommate, stated at times, Resident #7 wanted out of the room and staff shut the door. He stated resident #7 liked to be in the common area.On 2/25/26 at 10:54 a.m., Staff F, Registered Nurse(RN) stated Resident #7 did not like to be in his room. He liked sitting by the nursing station people watching. She stated staff were aware of what he wanted because he would grunt and point. At first, Staff F stated she was not aware of any staff members who placed the resident in his room when he wanted out. Upon further questioning, Staff F stated Staff E, CNA reported to her that Staff A, CNA placed the resident in his room and closed the door. She stated Staff E told her that Resident #7's roommate alerted the call light. Staff E stated that Staff A entered the room and asked the resident what was wrong and he pointed at the door like he wanted to go out. Staff E stated Staff A told the resident that she would be back in a minute and closed the door. Staff F stated she was not sure what day Staff E reported this to her but it was in the last week. Staff F stated she did not feel that this incident occurred on the day Staff E reported it to her, but a couple weeks prior. She stated she reported this to the Director of Nursing(DON) in passing. She stated her expectation was for staff to bring the resident out of his room if this was his wish. On 2/25/26 at 11:32 a.m., Staff A, CNA denied that she closed the door and would not allow the resident out of his room. She stated she was able to determine some of the resident's wishes per his gestures. For example, the resident made a driving motion when he wanted to go somewhere and also pointed and made noises. She stated this last weekend, she did not think she took care of him as she wasn't assigned to his hall. On 2/25/26 at 11:40 a.m., the DON stated she would want staff to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report it if someone placed a resident in their room and closed the door against their wishes. She stated no one reported anything of this nature to her. She stated Resident #7 loved to be out in the common area. She stated if someone notified her of this, she would have suspended the staff member while the investigation was pending. On 2/25/26 at 11:50 a.m., the Administrator stated staff should report allegations of abuse to her or the DON. She stated she would separate (the alleged perpetrator) from residents to make sure they were safe. She stated she would complete an investigation and report the allegation to the State Agency. The Administrator stated no one reported to her any concerns related to Staff A. She stated Resident #7 preferred to be out in the common area and agreed that if he gestured that he wanted out of his room, staff should honor his wishes. She stated she would suspend Staff A.On 2/25/26 at 2:28 p.m., the Administrator stated staff should treat residents with kindness and they should be free from abuse. The facility lacked documentation they reported the allegation of the abuse to the State Agency prior to 2/25/26.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to investigate an allegation of abuse and ensure resident safety during the investigation for 1 of 2 residents reviewed for abuse(Resident #7). The facility reported a census of 62 residents.Findings: 1. The Minimum Data Set(MDS)assessment tool, dated 12/11/25, listed diagnoses for Resident #7 which included cerebral palsy(a disorder caused by brain abnormalities and characterized by symptoms including difficulty with movement, muscle tone, and balance), severe intellectual disabilities, and a history of healed traumatic fractures. The MDS stated the resident was dependent on staff for toileting and dressing, required partial to moderate assistance for transfers, and did not walk during the review period. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 1 out of 15, indicating severely impaired cognition. The facility Abuse Policy, dated June 2023, stated residents had the right to be free from abuse and to be treated with respect and dignity. The policy defined abuse to include involuntary seclusion. The facility would report abuse to the State Agency within 2 hours and complete a timely and thorough investigation. The policy did not specifically address how the facility would protect residents during the investigation. A 12/8/25 Care Plan entry stated Resident #7 liked to spend time in the common area watching tv, listening to music, and people watching. A 12/10/25 Care Plan entry stated Resident #7 had impaired cognitive function and was able to make basic needs known through body language and saying yeah or nah. The February 2026 Documentation Survey Report V2 documented on 2/21/26 during the day shift(6:00 a.m. to 2:00 p.m.), Staff A Certified Nursing Assistant(CNA) provided the resident with assistance including the following activities of daily living: chair to bed transfers, dressing, oral hygiene, personal hygiene, and toilet transfers.On 2/24/26 at 3:42 p.m., Staff E CNA stated that last Saturday(2/21/26) Resident #7 made vocalizations and Staff A CNA placed him in his room and closed the door so she wouldn't have to hear him. She stated she reported this to Staff F Registered Nurse(RN). Staff E stated the resident didn't like being in his room and he was in there 45 minutes to 1 hour. In a follow-up interview on 2/24/26 at 3:49 p.m., Staff E stated that the resident's roommate was also present in the room at the time this happened. On 2/25/26 at 8:14 a.m., Resident #8, resident #7's roommate, stated at times, Resident #7 wanted out of the room and staff shut the door. He stated resident #7 liked to be in the common area.On 2/25/26 at 10:54 a.m., Staff F, Registered Nurse(RN) stated Resident #7 did not like to be in his room. He liked sitting by the nursing station people watching. She stated staff were aware of what he wanted because he would grunt and point. At first, Staff F stated she was not aware of any staff members who placed the resident in his room when he wanted out. Upon further questioning, Staff F stated Staff E, CNA reported to her that Staff A, CNA placed the resident in his room and closed the door. She stated Staff E told her that Resident #7's roommate alerted the call light. Staff E stated that Staff A entered the room and asked the resident what was wrong and he pointed at the door like he wanted to go out. Staff E stated Staff A told the resident that she would be back in a minute and closed the door. Staff F stated she was not sure what day Staff E reported this to her but it was in the last week. Staff F stated she did not feel that this incident occurred on the day Staff E reported it to her, but a couple weeks prior. She stated she reported this to the Director of Nursing(DON) in passing. She stated her expectation was for staff to bring the resident out of his room if this was his wish. On 2/25/26 at 11:32 a.m., Staff A, CNA denied that she closed the door and would not allow the resident out of his room. She stated she was able to determine some of the resident's wishes per his gestures. For example, the resident made a driving motion when he wanted to go somewhere and also pointed and made noises. She stated this last weekend, she did not think she took care of him as she wasn't assigned to his (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hall. On 2/25/26 at 11:40 a.m., the Director of Nursing(DON) stated she would want staff to report it if someone placed a resident in their room and closed the door against their wishes. She stated no one reported anything of this nature to her. She stated Resident #7 loved to be out in the common area. She stated if someone notified her of this, she would have suspended the staff member while the investigation was pending. On 2/25/26 at 11:50 a.m., the Administrator stated staff should report allegations of abuse to her or the DON. She stated she would separate (the alleged perpetrator) from residents to make sure they were safe. She stated she would complete an investigation and report the allegation to the State Agency. The Administrator stated no one reported to her any concerns related to Staff A. She stated Resident #7 preferred to be out in the common area and agreed that if he gestured that he wanted out of his room, staff should honor his wishes. She stated she would suspend Staff A.On 2/25/26 at 2:28 p.m., the Administrator stated staff should treat residents with kindness and they should be free from abuse. The facility lacked documentation they carried out an investigation or separated residents from Staff A prior to 2/25/26.