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	08/14/2025

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

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to complete and transmit Comprehensive Minimum Data Set (MDS) Assessments following a significant change within federal guidelines for 2 of 2 residents (#37 & #60) reviewed for Hospice Admission. The facility reported a census of 54 residents. Findings include: 1. The Census Line portion of the Electronic Health Record (EHR) of Resident #37 documented the resident enrolled in hospice care on 1/27/25. The Significant Change MDS of Resident #37 documented an Assessment Reference Date (ARD) of 2/2/25. Page 58 of the MDS documented the MDS was signed as Assessment Completion on 2/15/25, 20 days following hospice admission. 2. The Census Line portion of the Electronic Health Record (EHR) of Resident #60 documented the resident enrolled in hospice care on 6/20/25. The MDS screen of Resident #60 failed to reveal any significant change MDS assessment was completed on Resident #60. On 8/14/25 at 11:20 am, the MDS Coordinator reviewed the MDS screen and verified no significant change MDS had been done for this hospice enrollment. According to the 2024 RAI, a Significant Change (comprehensive) assessment, the ARD must be no later than the 14th calendar day after determination that a significant change in the resident's status occurred. The RAI stated a Significant Change MDS is required to be performed when a terminally ill resident enrolls in a hospice program. The facility policy titled Change in a Resident’s Condition or Status, revision date February 2021, documented the following: Point 9: If a significant change in the resident’s physical or mental condition occurs, a comprehensive assessment of the resident’s condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction Manual.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR) review, staff interview, and guidance form the 2024 Resident Assessment Instrument (RAI), the facility failed to submit accurate resident information on the Comprehensive Minimum Data Set (MDS) Assessments for 2 out of 19 residents reviewed for MDS assessments (Residents #6 for weight loss and #16 for mental illness diagnosis). The facility reported a census of 54. Findings include:1. 1. The Quarterly MDS assessment completed on 6/11/25 revealed Resident #6 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses on the MDS include diabetes, heart failure, morbid obesity, peripheral vascular disease, and renal insufficiency. The MDS further noted the presence of a colostomy, stage 3 pressure injuries, and urinary catheter. The recorded weight on the MDS Section K -Swallowing /Nutritional Status was entered at 235 pounds and noted as No or Unknown for weight loss of 5% or more in the last month or loss of 10% or more in the last six months.The documented weights in the EHR noted the following:a. 272.0# on 11/13/24b. 272.3# on 12/9/24c. 259.2# on 1/13/25d. 253.8# on 2/2/25e. 234.0# on 3/1/15f. 235# on 5/14/25Due to lack of a documented weight for April 2025, unable to determine if a 5% significant weight loss occurred in the past month. However, a significant weight loss of 10% or more did occur in the previous six months and was not noted on the MDS completed 6/11/25. 2. 2. The Annual MDS assessment completed on 5/28/25 revealed Resident #16 with a BIMS of 14, indicating intact cognition. Diagnoses on the MDS in Section I (Active Diagnoses) include bipolar disorder, depression, and Parkinson's disease.The diagnosis tab of the EHR noted a bipolar disorder on 10/21/19, which was identified from a previous short-term facility admission.The PASRR Notice of Nursing Facility Approval, dated 8/26/20, noted Resident #16 meets criteria for having a diagnosis of a mental illness as defined by PASRR. Bipolar disorder, Not otherwise specified was identified.Section A1500 Preadmission Screening and Resident Review (PASRR) of the MDS was checked No on the MDS completed 5/28/25. This question asked if the resident is considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition.During an interview on 8/14/25 at 11:30 AM, the MDS Coordinator acknowledged the weight loss section for Resident #6 was incorrectly answered on the MDS dated [DATE]. The MDS Coordinator explained the resident had a prolonged hospitalization and was on a weight loss medication, which was effective. Section K0300 should have been answered Yes, on a physician-prescribed weight loss regimen to a weight loss of 10% or more in the last six months.The MDS Coordinator acknowledged Resident 16's bipolar diagnosis and noted Question A1500 was incorrectly answered on the MDS dated [DATE]. Question A1500 should have been answered Yes which would direct staff to answer question A1510 Level II PASRR Conditions. The 2024 RAI stated the following for coding instructions:a. Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order.b. Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related conditions, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, electronic health record review (EHR), staff interview, and policy review, the facility failed to update resident Care Plans in a timely manner to reflect current conditions and interventions for 5 of 19 resident Care Plans reviewed (Residents #4, #6, #22, #26, and #46). The facility reported a census of 54 residents.Findings include: 1. The Quarterly Minimum Data Set (MDS) Assessment completed on [DATE] revealed Resident #4 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses on the MDS include diabetes and end stage renal disease (ESRD). The Care Plan for Resident #4, last revised on [DATE], listed an intervention for the use of Lido/Prilcn (a topical numbing cream under the Brand Name Emla) applied to the right fistula on Monday, Wednesday, and Friday. The Progress Note dated [DATE] documented the facility receiving a fax from the dialysis unit to discontinue EMLA due to patient complaints of itching. [DATE]’s Treatment Administration Record (TAR) showed the Lido/Prilo was discontinued on [DATE]. During an interview on [DATE] at 11:30 AM, the MDS Coordinator acknowledged the intervention for the use of Lido/Prilo. The MDS Coordinator explained there had been changes to the type of cream used and confirmed another class of medicated cream is currently in use. The Care Plan should reflect this change. While any staff member can update the Care Plan as needed, the MDS Coordinator is ultimately responsible for updates. 2. The Quarterly MDS completed on [DATE] revealed Resident #6 with a BIMS score of 15, indicating intact cognition. Diagnoses on the MDS include diabetes, heart failure, morbid obesity, peripheral vascular disease, and renal insufficiency. The MDS noted the presence of a colostomy, stage 3 pressure injuries, and urinary catheter. The weight on the MDS noted at 235#. The Care Plan for Resident #6, last revised on [DATE], listed an intervention for the use of negative pressure wound therapy (NPWT) to the resident’s abdominal surgical wound from an ostomy revision. This was added on [DATE]. The Care Plan listed a goal for Resident #6s’ weight to trend between 255-275# through the next review date. An Order Audit Report obtained on [DATE], indicated the NPWT was initiated on [DATE] and discontinued on [DATE]. Documented weights in the EHR showed Resident #6’s weight has been trending between 234-237# from [DATE] to present. During an interview on [DATE] at 4:00 PM, the Registered Dietitian explained they will typically review and update resident's Nutritional Plan of Care with each schedule MDS Assessment. The RD acknowledged the lack of nutrition Care Plan updates. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:30 AM, the MDS Coordinator acknowledged the intervention for the NPWT. The MDS Coordinator confirmed the NPWT had been discontinued. While any staff member can update the Care Plan as needed, the MDS Coordinator is ultimately responsible for updates. 3. The Quarterly MDS completed on [DATE] revealed Resident #22 with a BIMS score of 0, indicating a severe cognitive impairment. Diagnoses on the MDS include Alzheimer’s disease, cancer, coronary artery disease, diabetes, heart failure, and non-Alzheimer’s dementia. The weight on the MDS noted at 177#. The Care Plan for Resident #22, last revised on [DATE], listed a goal weight to trend between 160-170# through the next review date. Interventions included in this Focus area include weight loss to be unavoidable (initiated on [DATE] and revised on [DATE]) and resident has refused house supplement (initiated [DATE] and revised on [DATE]). Documented weights in the EHR showed Resident #22’s weight up and trending between 159-182# from February 2025 to present. Current Physician Orders listed the use of a protein supplement daily for wound healing, which was initiated on [DATE]. Neither the skin alteration nor the nutrition focus areas of the Care Plan include the supplement use a a current intervention. During an interview on [DATE] at 4:00 PM, the Registered Dietitian explained they will typically review and update resident's Nutritional Plan of Care with each schedule MDS Assessment. The RD acknowledged the lack of nutrition Care Plan updates. 4. The Significant Change in Status MDS for Resident #26 dated [DATE] section M-Skin Conditions documented pressure ulcer/injury Stage 3, 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. The MDS further documented Skin and Ulcer/Injury treatments: pressure reducing device for chair and bed. Prior MDS for Resident #26 dated [DATE] section M-Skin Conditions documented there was no risk for pressure ulcer/injury. The MDS further documented Skin and Ulcer/Injury treatments: pressure reducing device for chair and bed. The Care Plan document Resident #26 was at risk of skin breakdown related to history of skin breakdown on her bottom and low body fat level. Has actual skin impairment of stage 3 pressure to left buttocks, dated [DATE]. Interventions listed: “assess for and provide appropriate pressure-relieving devices as per PT/OT recommendations: chair cushion, mattress.” During a wound care treatment observation of Resident #26 on [DATE] at 10:30 am there was no cushion noted in the recliner where Resident #26 was seated. Staff A, LPN could not locate the chair cushion in the room. At that time the MDS coordinator stated the resident refused the cushion and was not using it consistently. The Care Plan for Resident #26 did not reflect alternative interventions or the history of refusal of the cushion. The MDS coordinator stated she will inquiry Physical Therapy/Occupational Therapy (PT/OT) for other alternatives. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:45 am with the DON confirmed Resident #26 did not like to use a cushion in her chair and that the Care Plan did not reflect her preferences. 5. An observation of Resident #46 on [DATE] at 11:55 am revealed staff used a mechanical lift to transfer her from her recliner to a wheelchair for lunch. A review of the Electronic Health Record (EHR) document titled “Care Plan” for Resident #46 documented advanced directive of Full Code, cardiopulmonary resuscitation (CPR) dated [DATE]. It also documented staff assistance of 2 with transfers using a front-wheel-walker and a gait belt, dated [DATE]. On [DATE], the Care Plan noted Resident #46 was on Hospice services and will have frequent 1-1 visits with her providers. During an interview on [DATE] at 2:11 pm, Staff A, Licensed Practical Nurse (LPN) stated in case of an emergency she looks in the EHR for the code status. Staff A stated they have physical charts/ paper charts located behind the main nurses station. After documents are uploaded into the EHR, then they can be filed in the paper charts. She stated some paperwork doesn't get filed immediately because they don't have a designated staff to do that task. She stated the PCC is the first and main place to look for any health-related information for the patient and paper-based charts are only for a back-up. The MDS for Resident #46 dated [DATE] documented Hospice services were added. It also documented functional abilities for mobility as “substantial/maximal” staff assistance required with transfers. During an interview on [DATE] at 10:25 am with the Director of Nursing (DON), she confirmed the Care Plans were not updated for Resident #26 and #46 to reflect changes in health status and current needs. She stated her expectations were that the Care Plans reflected current health status for each resident. The policy Care Plan: Comprehensive Person-Centered, revision date [DATE], revealed the following: a. The comprehensive, person-centered care plan is developed within seven days of the required MDS assessments (admission, annual or significant change) b. Care Plan interventions are derived from a thorough analysis of information gathered as part of the assessment c. The Care Plan describes services that are to be furnished to attain or maintain the resident’s highest practicable well-being d. Services provided for or arranged by the facility e. Assessments of residents are ongoing and Care Plans are revised as information about the residents and resident conditions changes f. The Interdisciplinary Team reviews and updated the Care Plan when there has been a significant change in the resident’s condition, when the desired outcome is not met, and at least quarterly, in conjunction with the required quarterly MDS assessment

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on electronic health record review, resident and staff interview, and policy review, the facility failed to consistently complete pre and post dialysis assessments for 1 of 1 residents reviewed for dialysis (Resident #4). The facility reported a census of 54. Findings include: The Quarterly Minimum Data Set (MDS) Assessment, completed on 7/9/25, revealed Resident #4 with a Brief Interview for Mental Status score of 15, indicating intact cognition. Diagnoses on the MDS include diabetes and end stage renal disease. Current Physician Orders direct the completion of pre and post dialysis assessments on Monday, Wednesday, and Friday, which was initiated on 1/18/23. Review of monthly Treatment Administration Records revealed the following: No pre and post dialysis assessments identified for 4/14/25, 4/16/25, and 4/23/25No pre and post dialysis assessments identified for 5/2/25, 5/9/25, 5/12/25, 5/16/25, and 5/23/25No pre and post dialysis assessments identified for 7/7/25 and 7/11/25; No pre-dialysis assessment identified for 7/4/25No pre and post dialysis assessment identified for 8/11/25During an interview on 8/11/25 at 1:30 PM, Resident #4 unable to recall if staff obtains vitals (blood pressure, pulse) before going to dialysis. The resident believes staff obtain blood pressures upon their return from dialysis. During an interview on 8/14/25, the Administrator and Director of Nursing both acknowledged the lack of dialysis assessments on the identified dates.The facility unable to provide a policy which outlines a procedure for the completion of pre and post dialysis assessments.

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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 2 of 3 residents reviewed for nutrition (Residents #4 and #22). The EHR lacked Nutrition Progress Notes and Assessments for the past nine months. The facility reported a census of 54. Findings include: 1. The Quarterly Minimum Data Set (MDS) Assessment completed on 7/9/25 revealed Resident #4 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses on the MDS include diabetes and end stage renal disease (ESRD). The Care Plan, last revised on 7/8/25, included a Focus Area related to the potential risk for altered nutritional status due to ESRD and diabetes. Interventions include the use of a protein supplements on non-dialysis days, monitor for signs and symptoms of malnutrition (cachexia, muscle wasting, significant weight loss), and the Registered Dietitian (RD) to consult quarterly and as indicated. Review of the EHR revealed the last identified nutrition documentation was a Dietary Assessment form completed on 4/18/24. 2. The Quarterly MDS Assessment completed on 7/2/25 revealed Resident #22 with a BIMS score of 0, indicating a severe cognitive impairment. Diagnoses on the MDS include Alzheimer's disease, cancer, diabetes, heart failure and non-Alzheimer's dementia. The MDS noted Resident #22 receives a mechanically altered diet. The Care Plan, last revised on 7/1/25, included a Focus Area related to the risk for impaired nutrition due Alzheimer's, dysphagia (swallowing difficulties), and a mechanically altered diet. Interventions include a puree diet order with nectar-thick liquids, history of weight loss, the use of adaptive equipment during meals, and past refusal of the house nutritional supplement. Review of the EHR revealed the last identified nutrition documentation was a Nutrition Risk Assessment form completed on 9/19/24. During an interview on 8/13/25 at 11:50 AM, the Director of Nursing (DON) attempted to located current RD documentation in the EHR but could not. The DON explained the RD is at the facility weekly but was unclear of the RD's charting process. During an interview on 8/13/25 at 3:20 PM, the DON explained RD Progress Notes for Resident #4 and Resident #22 have been scanned into the EHR. The scanned documents showed monthly RD Progress Notes for Resident #4 from January '25 to July '25 and for Resident #22 from March '25 to August '25. The DON explained they were not aware of the RD's current charting practices. The DON would expect RD Progress Notes/Assessments be entered into the EHR timely and to ensure staff have access. During an interview on 8/13/25 at 4:00 PM, the RD confirmed nutrition-related entries are documented on a jump drive that they maintain. The RD noted the facility does have access to the jump drive but it is unavailable today. Resident nutrition Progress Notes had been previously printed and sent to the facility. The RD explained this process has not been routinely completed for an unknown time frame.

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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 observations, clinical record review, staff interview, and policy review, the facility failed to maintain infection control standards as staff did not wear gloves when administered an injection for 1of 1 resident (Resident #53) and failed to apply personal protective equipment (PPE) when provided hands on care for a resident on enhanced barrier precautions for 1 of 3 residents (Resident #16). The facility reported a census of 54 residents. Findings include: 1.Observation on 8/12/2025 at 11:26 AM, Staff A, Licensed Practical Nurse administered an insulin injection to Resident #53 with no gloves on. Interview at 8/12/25 at 11:45, Staff A stated she realized she did not wear gloves for the injection and that she should have. Interview on 8/13/2025 at 8::00 AM, the Director of Nursing (DON) stated her expectation for staff to always wear gloves when administering an insulin injection. Facility policy Personal Protective Equipment-Gloves revised July 2009, documented the use of disposable gloves is indicated during invasive procedures. 2. Observation on 8/12/2025 at 10:58 AM, Staff B, Certified Medication Aide applied gloves, no gown, and entered Resident # 16's room. Staff B placed her hands on Resident #16's shoulders and assisted resident to an upright position. After Staff B exited the resident's room, Staff B stated she should have had a gown on also to reposition resident as the resident was on enhanced barrier precautions and required a gown and gloves for hands on care. Interview on 8/12/25 at 11:15 AM, the DON acknowledged she observed Staff B staff did not have the proper PPE on to assist the resident and stated her expectation for staff to wear PPE of gown and gloves with resident contact for residents on EBP. Facility policy Enhanced Barrier Precautions revised December 2024, documented EBPs employ targeted gown and glove use during high contact resident care activities with examples of high-contact resident care activities requiring the use of gown and gloves for EBPS include: providing bed mobility.