

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER Prairie Vista Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2785 1st Avenue S Altoona, IA 50009	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record reviews staff interview, and facility policy review, the facility failed to ensure that 1 out of 5 residents reviewed (Resident #36) for medications were provided with information, education regarding the risks and benefits of psychotropic medications or choice of alternatives and options. The facility reported a census of 45 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment of Resident #36, dated 5/3/26 documented diagnoses that included: Non-Alzheimer's dementia and mood disorder. The MDS coded Resident #36 took high-risk medications included, antipsychotic, antianxiety and antidepressants. The MDS recorded a Brief Interview for Mental Status (BIMS) score of 11, indicated moderate cognitive impairment. The Care Plan for Resident #36 initialed 7/3/24 relayed took psychotropic and anti-psychotic medications daily related to mood disorder and history of alcohol dependence. The Medication Administration Record (MAR) of Resident #36 for May 2026 documented orders for the following psychotropic medications. Olanzapine (antipsychotic) 10 milligram (mg), daily for delirium, agitation, dementing illnesses with behavioral symptoms, start date 7/31/24 Olanzapine 5 mg as needed for delirium, agitation related to mood disorder for ninety days, start date 2/26/26 Mirtazapine (antidepressant) 15 mg daily for sleep related, mood disorder, start date 2/19/26 Trazodone (antidepressant) 75 mg nightly for sleep, start date 2/2/26 Melatonin 5 mg daily for insomnia, start date 11/19/25A Psychoactive Medication Therapy Informed Consent form signed 2/20/26 was provided for Resident #35 signed by the representative and medical provider documented Olanzapine 5 mg had been prescribed for delirium, agitation for mood disorder. The facility could not provide any other consent forms. On 5/21/26 at 12:45 PM the Administrator relayed would be working on a plan in place to improve process for ensuring consent forms per new regulations. A policy titled Medication Regimen Reviews, revised 7/2024 documented, medication regimen and associated treatment goals involve collaboration with the resident (or representative), family members, and the interdisciplinary team (IDT), includes a review of the resident's or representative's stated preferences, the comprehensive care plans and information provided about the risks and benefits of the medication regimen.		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, clinical record review, and Iowa Physician Orders for Scope of Treatment, (I-POST) documents the facility failed to ensure consistency with process's to ensure clear direction with Cardiopulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) code status for 3 of 16 reviewed for Advance Directives (Resident #4, #36, #40) . The facility reported a census of 45 residents. Findings include:1.Resident #4 I-POST documented, Do Not Resuscitate (DNR) signed Resident #4 and by the medical provider with signature date [DATE]. Resident #4 Electronic Record Profile and Order Summary documented Code Status, CPR/Attempt resuscitation. 2.Resident #36 I-POST documented, DNR with signature date of [DATE]. Resident #36 Electronic Record Profile and order summary documented Code Status, DNR 3.Resident #40 I-POST documented, DNR with signature date [DATE]. Resident #40 Electronic Record Profile and order summary documented Code Status, DNR An observation on [DATE] and [DATE] revealed circled magnets on shared door of Resident #40 and Resident #36 , a green color to designate CPR and a red circle to designate DNR. On [DATE] at 2:00 PM Register Nurse (RN) Staff A explained all resident code status is revealed to staff by various methods included the binder with I-POST documents or the electronic record or could see a red magnet circle on the resident's door to indicate DNR or a green circle magnet to designate CPR. On [DATE] at 10:28 AM, Licensed Practical Nurse (LPN) Staff B relayed would go to the electronic record, the profile page and to the orders summary page for resident advance directives. Staff B relayed the magnets on residents' doors also reflected code status. Inquired about one green and one red magnet on shared room of Resident # 36 and #40. Staff B responded the green magnet referred to Resident #40 choice for CPR. On [DATE] at 11:55 AM the Administrator agreed code status for residents should be consistent to ensure residents wishes are followed. The Administrator relayed would correct discrepancies immediately.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical health record review, facility document review, resident interviews, staff interviews, and policy review, the facility failed to ensure residents were free from exploitation for 2 of 45 residents reviewed for abuse (Residents #10 and #18). Staff E, Licensed Practical Nurse (LPN), stole resident pain medications and documented the medications were administered to the residents. These actions continued until Staff E was suspended and terminated. The facility reported a census of 45. Findings include: 1. The Minimum Data Set (MDS) Assessment completed on 4/5/26 revealed Resident #10 with a Brief Interview for Mental (BIMS) Status score of 15, indicating intact cognition. This score is consistent with the previous BIMS from past assessments. Per the MDS from 10/5/25, Resident #10 reported occasional pain which rarely interfered with sleep. Pain was rated at a 6 out of 10, with zero representing no pain and 10 representing the worst pain possible. The Care Plan, last revised on 4/21/26, noted Focus Areas related to pain due to history of muscle tear and osteoarthritis (joint disease related to wear and tear) of the knees. Interventions include contacting the physician as needed for pain medication adjustments, daily scheduled pain medications, which include the use of an opioid (narcotic pain medication). The Care Plan also noted Resident #10 is able to express themselves when in pain and in need of further interventions or repositioning. The September and October 2025 Medication Administration Record (MAR) included the following pain medications: A. Hydrocodone-Acetaminophen (Narco) one 10-325mg tablet administered three times daily, initiated on 6/9/25 B. Hydrocodone-Acetaminophen (Narco) one 7.5-325mg tablet administered one time daily during the evening medication pass, initiated on 10/19/22 C. Acetaminophen two 325mg tablets administered as needed (PRN) for pain or temperature 100 or above, initiated on 11/4/18 D. Hydrocodone-Acetaminophen (Narco) one 7.5-325mg tablet administered PRN for pain, initiated on 10/19/22 The Nurse's Note from 9/29/25 at 7:09 PM summarized Resident #10 as alert and oriented. The resident is able to make their own decisions, communicates effectively, and able to make their needs known. Resident #10 sleeps thru the night. Chronic pain rating 7-8/10 and receives scheduled pain medications The Visit Summary Progress Note from 10/7/25, completed by the rounding Advanced Registered Nurse Practitioner (ARNP) noted no interval changes or acute concerns per nursing staff. Resident sleeping OK. No complaints of pain and no signs of such noted by staff. No changes to be made today, all chronic conditions are stable. Plan to revisit in 2 months, sooner PRN. Review of the September 2025 MAR revealed the following administration of the PRN Hydrocodone-Acetaminophen 7.5-325mg tablets. All of the PRNs listed were administered by Staff E, Licensed Practical Nurse (LPN), and no other staff members. A. On 9/2/25 at 1:08 PM; Pain rated at an 8 with the intervention documented as ineffective B. On 9/3/25 at 1:16 PM; Pain rated at an 8 with the intervention documented as effective C. On 9/4/25 at 12:52 PM; Pain rated at an 8 with the intervention documented as effective D. On 9/9/25 at 1:06 PM; Pain rated at an 8 with the intervention documented as effective E. On 9/10/25 at 1:03 PM; Pain rated at an 8 with the intervention documented as effective F. On 9/16/25 at 12:59 AM: Pain rated at an 8 with the intervention documented as effective G. On 9/16/25 at 11:33 PM; Pain rated at an 8 with the intervention documented as effective H. On 9/17/25 at 10:52 PM; Pain rated at an 8 with the intervention documented as effective I. On 9/19/25 at 3:24 AM; Pain rated at an 8 with the intervention documented as effective J. On 9/21/25 at 1:21 PM; Pain rated at an 8 with the intervention documented as effective K. On 9/23/25 at 12:21 AM; Pain rated at an 8 with the intervention documented as effective L. On 9/23/25 at 9:03 PM; Pain rated at an 8 with the intervention documented as effective. (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as effective M. On 9/29/25 at 9:40 PM; Pain rated at an 8 with the intervention documented as effective The Nurse's Note dated 9/4/25 at 12:56 PM documented Resident #10 complained of right leg pain at an 8 out 10. No further documentation identified in the clinical health record related to the other pain medication administration. No further explanation of pain location, how it affected sleep, use of non-pharmacological interventions, or that the physician was notified due to consistent use of the PRNs. Review of the October 2025 MAR revealed the following administration of the PRN Hydrocodone-Acetaminophen 7.5-325mg tablets. All of the PRNs listed were administered by Staff E and no other staff members. A. On 10/6/25 at 10:27 PM; Pain rated at an 8 with the intervention documented as effective B. On 10/8/25 at 1:31 AM; Pain rated at an 8 with the intervention documented as effective C. On 10/9/25 at 12:44 AM; Pain rated at an 8 with the intervention documented as effective D. On 10/9/25 at 11:06 PM; Pain rated at an 8 with the intervention documented as effective E. On 10/13/25 at 10:13 PM; Pain rated at an 8 with the intervention documented as effective F. On 10/15/25 at 12:01 AM; Pain rated at an 8 with the intervention documented as effective G. On 10/16/25 at 12:55 AM; Pain rated at an 8 with the intervention documented as effective No further documentation identified in the clinical health record related to the PRN pain medication administration. No further explanation of pain location, how it affected sleep, use of non-pharmacological interventions, or that the physician was notified due to consistent use of the PRNs. Review of the November 2025 MAR revealed no PRN Hydrocodone-Acetaminophen 7.5-325mg was administered. Review of the December 2025 MAR revealed a PRN Hydrocodone-Acetaminophen 7.5-325mg tablet was administered on 12/28/25 at 2:20 AM. Pain was rated at a 7 with the intervention documented as effective. In an interview on 5/19/26 at 3:30 PM, Resident #10 reported chronic right leg pain due to ruptured quadricep muscle. A brace is worn to hold in place. Baseline pain level stated at a 7 out of 10. Schedule pain medications help keep pain manageable as does consistent medication times. Pain levels will drop down to a 4 after the medications. Resident #10 stated they are aware of the order for additional pain medication as needed. Resident #10 voiced no specific event or medical needs which would have resulted in increased pain or the need for additional pain medications. They typically do not ask for any PRN pain medications as the scheduled medications are effective. Resident #10 explained they are usually asleep by 9:00 PM and sleep through the night. If they do wake up during the night with pain, they are able to reposition themselves independently to alleviate the pain. Regarding the time frame from September to October 2025, Resident #10 unable to recall Staff E evaluating them for pain after falling asleep for the night. They do not recall asking Staff E for PRN pain medications. They do not feel Staff E brought pain medications and then took it away as they declined the intervention. During an interview on 5/20/26 at 2:23 PM, Staff A, Registered Nurse (RN), explained Resident #10 had both scheduled and as needed pain medications. Based on their nursing assessments, Staff A believes the resident's chronic pain is well managed with little to no use of PRN pain medications. Staff A does not recall the resident experiencing any acute episodes of increased pain. Resident #10 is fairly rigid with their schedule. They are typically in bed by 4:30 PM, asleep by 9:00 PM, and awake for the day at 4:00 AM. During the months of September and October, Staff A does not recall the resident voicing to them waking up in pain or needing any pain medications in the middle of the night. Staff A reported when Staff E worked the day shift, Resident #10 was given PRN medications more frequently. Staff A then noticed the same pattern when Staff E switched to the overnight shift. During an interview on 5/21/26 at 12:40 PM, Staff F, RN, acknowledged working with a Staff E at times. When this occurred, Staff E would prefer to manage the medication cart themselves rather than have a Certified Medication Aide (CMA) working alongside them. Staff E would explain they were used to giving (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/16/25 at 2:17 AM with no pain rating listed and the intervention documented as effective No further documentation identified in the clinical health record related to the PRN pain medication administration. No further explanation of pain rating or location, how it affected sleep, or use of non-pharmacological interventions. Review of the November and December 2025 MAR revealed no PRN Hydrocodone-Acetaminophen 5-325mg tablets were administered. During an interview on 5/21/26 at 11:21 AM, Resident #18 confirmed overall constant pain to their right knee. Medications help with the pain. In September/October, Resident #18 explained they were able to walk around, with a walker, and was not asking for any additional pain medications. Pain did not wake them up at night. Resident #18 does not recall Staff E asking them about pain nor waking up to check on them. The resident stated Staff E didn't do anything. During an interview on 5/21/26 at 12:40 PM, Staff F, RN, explained they had noticed Resident #18 taking pain pills during the night, which they felt was unusual for the resident. The pills were all administered by Staff E. The morning of 10/16/26 Staff F asked Resident #18 about pain management and how they slept. Staff F noticed they were given a pain pill during the night by Staff E. Resident #18 voiced sleeping fine and did not take any pain medications. After this conversation, Staff F alerted nursing administration about possible drug misappropriation. The facility document labeled Statement dated 10/17/25, detailed events from 10/26/25. Staff F noted Resident #18 was given PRN pain medication at 2:17 AM. Staff F also noted the resident received a PRN the previous three nights. Resident #18 denied receiving the medications during the night as well as any pain. Resident #18 stated they sleep through the night. Staff F then notified the Director of Nursing of these findings. The facility document labeled Admin Report-H.B dated 10/26/25, detailed the Facility Administrator's account of the events on 10/16/25. Clinical health record review revealed numerous occasions where PRN pain medications were administered to Residents #10 and #18 over the past three months. All on various shifts and almost all documented by Staff E. No other nurses, including those working the same shift and hall during Staff E's days off, documented the use of PRN pain medications. Staff E was adamant the residents asked for the medications. Staff E agreed to a drug test but stated they were taking prescription pain medications. Staff E agreed to bring a copy for the active prescription, which they did on 10/17/25. The facility document labeled Stmt dated 10/17/25, detailed Staff G's account of the events on 10/16/25. Staff G talked with Resident #18 about needing any pain medications the night before. Resident #18 responded they never have any pain at night and doesn't need the pills. They have pain during the day when up. When Staff G asked about PRN medications during the night, Resident #10 replied they have been sleeping well without pain for quite some time and confirmed not receiving pain medications during the overnight hours. The facility documented labeled Admin Final Report detailed results of the facility investigation. The facility terminated Staff E on 10/24/25 due to creating an environment of suspicion and mistrust. Staff E continued to deny any wrongdoing but appeared to understand the reasoning. During an interview on 5/26/26 at 2:00 PM, the Facility Administrator explained nursing administration staff notified them of a possible situation the morning of 10/16/25. Staff E documented providing Residents #10 and #18 with PRN narcotic pain medications but residents denied receiving. Review of video footage from the overnight shift, Staff E seen obtaining resident pain medications and entering residents' rooms at the documented administration times. Since the medications were PRNs, residents would have had to notify staff of discomfort and asked for the medication. Video footage does not show Staff E or any other staff member entering resident rooms prior Staff E going in with pain medications. Reports did not show the residents utilized their call lights to alert staff they needed assistance prior to Staff E entering the rooms with pain medications. Staff E was contacted on 10/16/25 to discuss the situation further and to notify they were (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility record review, family interview, staff interviews, and policy review, the facility failed to provide services to protect the resident from accidents or hazards by not ensuring the correct mechanical lift sling was used resulting in the resident sliding out from the sling (Resident #7). The facility reported a census of 45. Findings include: The Minimum Data Set (MDS) Assessment completed 3/1/26 revealed Resident #7 was not able to complete a Brief Interview for Mental Status. The resident was noted to be severely cognitively impaired for daily decision making. Medical diagnoses include dementia with a weight of 147#. The MDS noted Resident #7 is dependent on staff for all transfers, such as chair/bed to chair. The Care Plan with a Target Date of 8/29/26 noted Resident #7 is not able to complete self-cares due to dementia diagnosis. Interventions include the use of a mechanical lift with two staff members. This was initiated on 6/2/25. The intervention was updated on 4/8/26 to include the use of a medium/purple sling. The weight capacity of the medium sling is 125-200#. The Progress Note dated 4/5/26 at 7:10 PM, documented Resident #7 had slid out of the mechanical lift sling. Upon arrival the nurse found the resident laying on her back on the floor. No signs or symptoms of pain or injury. The undated Root Cause Analysis of the incident identified the incorrect mechanical lift sling size had been used during the transfer. Staff did not verify the correct sling size needed for the resident. During a family interview on 5/20/26 at 1:00 PM, Resident #7's spouse noted they were present during the incident. They explained staff was in the process of lifting the resident up out of the wheelchair when they slipped through the bottom of the sling. During an interview on 5/20/26 at 1:32 PM, Staff C, Certified Nursing Assistant (CNA), confirmed they were present during the incident where Resident #7 was being transferred from a wheelchair to the bed. The mechanical lift sling used was the one that had been in use during the day and already in place in the wheelchair. While in the beginning stages of lifting the resident in the air, the Staff C noted Resident #7 was a little restless and grabbing onto the sling itself. The next thing they knew, the resident had slid out of the sling and landed on their buttocks. Staff C reported all the sling loops were hooked correctly. Staff C believed the resident had been sitting too high up in the sling. During a follow-up interview on 5/26/26 at 4:00 PM, Staff C explained the color of the [NAME] around the outside edges of the sling indicates the size of the sling. Staff C could not recall what size of sling was used at the time of the incident. During an interview on 5/21/26 at 11:10 AM, Staff D, Registered Nurse, confirmed they were the nurse responding to the incident involving Resident #7. Based on their observations and staff explanation, the resident slid out of the sling, buttocks first, through an opening that was created when the leg straps were crossed and hooked up to the mechanical lift. Staff D believed the sling used for the transfer was too big for the resident. After providing medical care, Staff D inspected the sling. The straps & loops were all intact. There were no frayed edges or loose stitching. Staff D believed the color of the mechanical lift (Hoyer) was green, which indicate a large sized sling (weight capacity of approximately 200-275#). The sling was immediately removed from the resident's room and taken out of service. During an interview on 5/21/26 at 3:00 PM, the Director of Nursing (DON) explained they were not on site at the time of the incident. However, the DON did see the sling the next day at the nurses station where it was placed after the incident. The DON confirmed the color of the sling was not purple (indicating medium size). They stated it may have been green. The DON reported Resident #7 has always utilized a medium sized sling for mechanical lift transfers. The facility utilizes Pocket Care Plans for staff to refer to for resident care information. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165610	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2026
NAME OF PROVIDER OR SUPPLIER Prairie Vista Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2785 1st Avenue S Altoona, IA 50009	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These are updated anywhere from 1-3 times per week and available to staff on a daily basis. Once updated, outdated Pocket Care Plans are not kept. During an interview on 5/26/26 at 12:00 PM, the Director of Clinical Services provided a summary of the facility's investigation of the incident. Resident #7 had moved their leg while in the mechanical lift sling and repositioned themselves. This then led to the resident sliding out the opening, which was larger than usual due to the incorrect sling sized being used. During a follow-up interview on 5/27/26 at 2:50 PM, the DON explained Pocket Care Plans list all resident using a mechanical lift and the resident's current sling size. This process had been in place prior to Resident #7's incident. Staff should be referring to these to ensure the correct size is being used. The policy Lifting Machine, Using a Mechanical, revised July 2024, noted the following: 1. Select sling size that is appropriate for the resident's size and task 2. Double check the sling and machine's weight limit against the resident's weight 3. Visually check the sling size the ensure it is not too large or too small just prior to attaching sling straps to the mechanical lift		