

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 16E016	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Virginia Gay Nursing & Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 502 North Ninth Avenue Vinton, IA 52349	
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on facility record review, interview, the Payroll Based Journal (PBJ) Staffing Data Report for Fiscal Year (FY) Quarter 2, 2026, and the Centers for Medicare & Medicaid Services Electronic Staffing Data Submission PBJ Long-Term Care Facility Policy Manual (CMS PBJ Manual) the facility failed to submit accurate staffing data to CMS for 1 of 1 quarter reviewed. The facility reported a census of 31 residents. Findings include: The facility PBJ Staffing Data Report dated FY Quarter 2 2026 (January 1 - March 31) documented the facility triggered for a one star staff rating, no RN (Registered Nurse) hours, and failure to have licensed nursing coverage for 24 hours per day. RN hours were flagged on 2/11/2026, 2/12/2026, 2/17/2026, and 2/18/2026. Nursing coverage for 24 hours was flagged on 1/15/2026, 1/27/2026, 1/28/2026, 1/29/2026, 2/3/2026, 2/4/2026, 2/5/2026, 2/10/2026, 2/11/2026, 2/18/2026, and 3/25/2026. Time cards provided by the facility dated 1/15/2026 through 3/25/2026 revealed the facility maintained adequate RN coverage as well as 24 hour nursing coverage. An email from the Administrator dated 7/14/2026 at 4:32 PM documented she was not sure why it did not register on the PBJ report. She noted the facility was short a few minutes for 8 hours of RN coverage on 2/11/2026 so that one was accurate but she was unable to determine what happened the other days. On 7/15/2026 at 8:19 AM the Administrator followed up and stated she still could not say why the hours were not registering. She stated that until a couple of months ago she didn't know there was a way to look up the errors. On 07/16/2026 at 1:14 PM the Administrator stated there were still errors showing up in the data she submitted this month, and she and another staff member continued to try to correct it. She reported she had not had training in this area and it was a work in progress. The CMS PBJ Manual, Version 2.7 dated June 2025, documented staffing information was required to be an accurate and complete submission of a facility's staffing records. Facilities should run the staffing and census reports available in the system to verify the accuracy and completeness of their final submission and the accuracy of their resident census prior to the submission deadline. Facilities that did not meet accuracy and deadline requirements were considered noncompliant and subject to enforcement actions by CMS.		

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility records, interviews, and the facility Quality Assurance Performance Improvement (QAPI) Plan the facility failed to ensure all required staff or a designee attended quarterly QAPI meetings and that the Infection Preventionist provided relevant infection control information to the committee. The facility reported a census of 31 residents. Findings include: A document titled N & R (Nursing and Rehabilitation) QAPI Meeting dated 8/11/2025 documented the Medical Director and the Interim Administrator were absent from the meeting. The list of attendees did not include designees for these roles. A document titled Nursing and Rehabilitation QAPI Meeting Minutes dated 2/19/2026 documented the Director of Nursing/Infection Preventionist (DON/IP) attended the meeting. The section titled infection control indicated no new concerns were identified during the 4th quarter. No infection control tracking information was documented in the minutes. A document titled Nursing and Rehabilitation QAPI Meeting Minutes dated 5/21/2026 indicated the Administrator and the Medical Director were absent from the QAPI meeting. There was not a designee assigned to attend the meeting by the Administrator or Medical Director. The attendees listed included the DON/IP. There was not documentation to indicate the committee discussed infection control tracking. During an interview with the DON/IP on 7/16/2026 at 9:08 AM, she stated there was a COVID outbreak in January. She stated she was the Infection Preventionist and responsible for giving updates to the QAPI committee. At 12:13 PM when asked about the notes in the QAPI minutes that indicated there were no new concerns, the DON/IP confirmed that if the minutes documented no new concerns were reported then the committee did not discuss infection control tracking or the COVID outbreak. During an interview with Staff B, Quality Improvement on 7/16/2026 at 12:19 PM, she stated meetings should include the Medical Director, the Administrator, the DON/IP, and department heads. She stated she thought the Medical Director could miss a meeting a year and sometimes they couldn't replace their attendance with someone else. They have held meetings without the Administrator. Staff B stated some infection control was discussed at QAPI but not every time. She stated they mostly discussed falls and medication errors. On 7/16/2026 at 12:42 PM, the Administrator stated she didn't know if the Medical Director had a designee to send to QAPI meetings and the Medical Director had never said she could send someone else. When asked how information got to the committee if she (the Administrator) or the Medical Director did not attend, she said she might send an email. She was not aware of the Medical Director sending information ahead of time. The Administrator stated the DON/IP mostly discussed falls and medication errors. When asked if the minutes report documented 'no new information' that meant there was not an infection prevention tracking report given to the committee, she stated she assumed there was not. The facility QAPI plan titled Quality Assurance and Performance Improvement plan, revised 2/12/2024, documented the QAPI committee should meet at least quarterly and consisted of, but was not limited to: The Director of Nursing Services, the Medical Director or his/her designee, the Nursing Home Administrator, and the Infection Preventionist. If any member of the committee was unable to attend for any reason either their supervisor or a delegate would present their data. The document was signed by the Medical Director, the Administrator, and Staff B.		

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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 review, policy review, and staff interviews, the facility failed to obtain consent and provide information about the risks and benefits of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for 3 of 5 residents reviewed for psychotropic medications (Residents #1, #3, #7). The facility reported a census of 31 residents. Findings include: 1. Review of the Minimum Data Set (MDS) assessment, dated 6/10/26, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated severe cognitive impairment. The MDS assessment listed a diagnosis of non-Alzheimer's dementia for the resident. The MDS indicated that Resident #1 took an antipsychotic medication. Review of the Care Plan, initiated 10/10/25, revealed a Focus care area for Resident #1's use of antipsychotic medication related to agitation. An intervention instructed educate the Power of Attorney (POA) on side effects on black box warning for antipsychotic medication as needed (initiated on 10/10/25). Review of the Order Summary, dated 7/16/26, revealed the following active order: a. REXULTI (Brexpiprazole) oral tablet 0.5 milligrams (mg) (antipsychotic medication used alongside antidepressants for major depressive disorder (MDD), to treat schizophrenia, and for agitation associated with Alzheimer's dementia) with instructions to give one tablet by mouth one time a day related to unspecified dementia, unspecified severity, with anxiety. Start date: 5/20/26. Review of Resident #1's clinical records lacked documentation that the facility informed the resident or the resident's representative of the risks and benefits of the medication, the treatment alternatives, or other options so the resident could make an informed choice. 2. Review of the MDS assessment, dated 6/29/26, revealed Resident #3 had a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included non-Alzheimer's dementia, Traumatic Brain Injury (TBI), seizure disorder, and depression. The MDS indicated that Resident #3 took antidepressant and anticonvulsant medications. Review of the Care Plan, initiated on 7/01/26, revealed a Focus care area for Resident #3's use of anti-anxiety medications related to end of life comfort. Interventions instructed the following, in part: a. Monitor the resident as needed for safety. The resident is taking anti-anxiety medications which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Date initiated: 7/01/26. b. Monitor, document, report as needed any adverse reactions to anti-anxiety therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgement, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Date initiated: 7/01/26. c. Monitor and record occurrence of target behavior symptoms and document per facility protocol. Date initiated: 7/01/26. Review of the Order Summary, revealed the following active order for Ativan (lorazepam) oral concentrate 2 mg/milliliter (mL) (benzodiazepine, anti-anxiety medication used to treat anxiety disorders, severe agitation, insomnia, and active seizures), with instructions to give 0.25mL by mouth every 2 hours as needed for anxiety/restlessness. Start date: 6/21/26. Review of Resident #3's clinical records lacked documentation that the facility informed the resident or the resident's representative of the risks and benefits of the medication, the treatment alternatives, or other options so the resident could make an informed choice. 3. Review of the MDS assessment, dated 6/03/26, revealed Resident #7 had a BIMS score of 15 out of 15, which indicated intact cognition. The MDS lacked mood or behavioral symptoms and lacked mood disorder diagnosis. The MDS identified that Resident #7 utilized antidepressant medication. Review of the Care Plan, initiated (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/03/26, revealed a Focus care area for Resident #7 's use of antidepressant medications. Interventions instructed to monitor/document/report as needed adverse reactions to antidepressant therapy. Adverse reactions listed as follows: change in behavior/mood/cognition, hallucinations/delusions, social isolation, suicidal thoughts, withdrawal, decline in activities of daily living ability, no voiding/constipation, fecal impaction, diarrhea, gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo, fatigue, insomnia, appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes. Review the Order Summary, revealed an active order for Sertraline (Zoloft) hydrochloride (antidepressant medication used to treat depression, anxiety disorders) 25mg oral tablet, with instructions to give 50mg by mouth one time a day for anxiety. Start date: 6/09/26. During an interview on 7/16/26 at 12:08 PM, the Director of Nursing (DON) stated consent for psychotropic medication use should be obtained upon admissions and with any new psychotropic medication orders. The DON confirmed that Resident #1, Resident #3, and Resident #7 were prescribed and administered psychotropic medications and lacked documentation of consent for psychotropic medication. During an interview on 7/16/26 at 1:00 PM, the facility Administrator denied having facility policy or procedures for obtaining psychotropic medication consents.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility record review, the facility failed to notify the State Ombudsman office of resident hospital transfers for 1 of 1 resident reviewed for transfers (Resident #9). The facility reported a census of 31 residents. Findings include: The clinical record for Resident #9, admitted on [DATE], documented diagnoses that included unspecified atrial fibrillation, cardiomyopathy, and chronic congestive heart failure. A Social Service Structured Progress Note dated 4/30/26 documented Resident #9 had a hospital stay on 4/18/26 due to cellulitis requiring intravenous (IV) medications. A Health Status Note dated 4/19/26 at 12:50 PM documented Resident #9 returned to the facility following a discharge from the hospital at 12:35 PM after receiving treatment for a skin infection. An email from the Administrator, dated 7/14/26 at 5:34 PM, confirmed that the facility lacked Ombudsman notification records for the month of April 2026. In an interview on 7/15/26 at 3:15 PM, the Administrator stated she was responsible for notifying the Ombudsman of resident admissions, discharges, hospitalizations, and deaths at the end of each month. The Administrator confirmed she had never completed this task before because she was new to her role, and admitted she forgot about it. She acknowledged that the facility had not submitted the required Ombudsman notifications since January of 2026. She further acknowledged that the facility should have notified the Ombudsman of Resident #9's hospitalization on 4/18/26. When asked for a copy of the facility's notification policy during the interview on 7/15/26 at 3:15 PM, the Administrator stated that the facility did not have a policy regarding Ombudsman notifications.		