

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165549	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Vista Woods Care Center			STREET ADDRESS, CITY, STATE, ZIP CODE THREE PENNSYLVANIA PLACE , OTTUMWA, Iowa, 52501	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 ✓ KG	INITIAL COMMENTS Correction date: 11/26/25 The following deficiency resulted from the facility's annual recertification survey and investigation of complaints #2561046-C and #2584416-C, conducted September 22, 2025 to September 25, 2025. Complaints #2561046-C and #2584416-C resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000	Please accept this Plan of Correction as the facility's Written Credible Allegation of Compliance.	11/26/2025
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	Resident Rights/Excercise of Rights. The facility protects and promotes the rights of residents in an environment that enhances his/ her quality of life. The facility ensures that staff respect the dignity of resident's, and privacy, while transporting them to and from shower rooms and during bathing. This deficiency has been corrected as it relates to Residents #5, #53 and #55 by the Director of Nursing (D.O.N.) and the Assistant Director of Nursing (A.D.O.N.) providing additional individual training to Staff members A and B during the survey on the proper transportation techniques of residents to and from shower room in a safe and dignified manner. Other residents in similar situations are protected by providing additional training to CNAs on a revised shower policy, transporting residents to and from shower rooms, the ability to transfer residents in the shower rooms, and the use of new adaptive privacy and safety showering equipment. These training inservices included training on Resident Rights and were held on 10/07/2025 and 11/07/2025. (continued)	11/26/2025

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 reverse for further 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 <i>Ron Sturano</i>	TITLE Administrator	(X6) DATE 11/23/2025
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F0550 SS = D	<p>Continued from page 1 §483.10(b) Exercise of Rights.</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on clinical record review, observation, facility policy review and staff interview, the facility failed to ensure staff respected the dignity of residents while transporting residents to and from the shower room for 3 of 4 observations of residents (Residents #5, #53 and #54) transported to the shower room by staff. The facility reported a census of 53. Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment for Resident #53, dated 7/9/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated a severe cognitive impairment. The resident assessed dependent on staff for bathing, and required maximum/substantial assistance for transferring. The MDS listed a diagnosis of diagnosis of dementia.</p> <p>Review of the Care Plan, last revised 7/10/25, identified Resident #53 dependent on staff for meeting emotional, intellectual, physical, and social needs. The resident required substantial/maximum assistance of one staff for bathing/showering, dependent on assistance of two staff with a gait belt and walker for ambulation, and dependent on one staff for wheelchair use.</p> <p>During an observation on 9/23/2025 at 7:36 AM, Resident #53 sat in a shower chair in the middle of the hallway approximately 8 feet from the shower room. The resident faced the south end of the hall, in the opposite direction of the bathing/shower room. The resident wore a gown, and had been covered with a blanket. Staff A,</p>	F0550	<p>(Continued from page 1) The facility has also purchased Privacy Shower Ponchos for residents and adaptive shower chair footrests.</p> <p>Measures taken to ensure that the problem does not recur includes the revision of the Shower Policy and the additional training of CNA's on that policy and Resident Rights, including privacy. The facility Quality Assurance (QA) Nurse, or designee, will do random observations of the CNAs during the process of showering residents for a three month period and provide additional individual training if needed.</p> <p>Performance will be monitored by the D.O.N. and/or the QA nurse to make sure that the solutions are permanent by reporting compliance to the QA&A committee on a quarterly basis.</p>	

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F0550 SS = D	<p>Continued from page 2</p> <p>Certified Nursing Assistant (CNA), approached Resident #53 and pulled the resident backwards in the shower chair approximately 8 feet into the shower room. While pulling the resident backwards, Staff A told the resident she could not push him forward, because the resident's chair did not have foot pedals on it.</p> <p>2. The MDS assessment for Resident #5, dated 8/6/25, indicated the resident had a BIMS score of 4 out of 15, which indicated a severe cognitive impairment. The resident dependent on staff for showering/bathing, transferring and lower body dressing. The MDS listed a diagnosis of dementia and anxiety.</p> <p>Review the Care Plan, last revised 8/12/25, identified Resident #5 dependent on staff for meeting emotional, intellectual, physical, and social needs. The resident required total assist of one staff for bathing/showering, did not ambulate, required assist of one for wheelchair use, and required total assist with a non-mechanical lift or assist of two staff using a gait belt.</p> <p>During an observation on 9/23/25 at 3:53 PM, Resident #5 sat in a shower chair at the entrance to her room. Staff B, CNA, pulled the resident backwards down the hallway from the resident's room to the shower room approximately 30 feet.</p> <p>During an observation on 9/23/25 at 4:12 PM, Staff B, CNA, pulled Resident #5 down the hallway in a shower chair with the resident facing the opposite direction of the direction pulled. Staff B pulled the resident backwards approximately 30 feet and stopped approximately 5 feet into the resident's room. The resident faced the open doorway, unclothed and covered with a sheet. When the resident shifted in the chair, she exposed herself from her abdomen to her feet.</p> <p>3. Review of the MDS assessment, dated 8/20/25, revealed Resident #54 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. The list of diagnoses included left femur fracture, adult failure to thrive, and adjustment disorder with depressed mood and anxiety. The MDS indicated Resident #54 required substantial to maximal staff assistance for bathing and transfers.</p> <p>Review of the Care Plan, last revised on 6/24/25, revealed Resident #54 required 1 staff, partial to moderate amount of assistance, for showering twice weekly and as necessary.</p> <p>During an observation on 9/23/25 at 1:06 PM, Staff A,</p>	F0550		

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F0550 SS = D	<p>Continued from page 3 CNA, transported Resident #54 in a shower chair through the hallway with a bath sheet placed over resident's lap. Staff A turned the shower chair to enter the shower room and Resident #54's unclathed left side, from her hip to foot was exposed</p> <p>During an interview on 9/24/2025 at 1:39 PM, Staff A, CNA, reported that when she placed the residents in shower chairs to transport to and from the shower, she would pull the resident down the hall backwards with the resident facing the opposite direction she was pulling. Staff A explained if she pushed a resident forward in the shower chair, the residents would be at risk of putting their feet down and breaking their feet.</p> <p>During an interview on 9/24/25 at 2:55 PM, Staff C, CNA, explained she thought staff treated residents with dignity and respect. Staff C reported that when she assisted residents with showers, she pushed them in their wheelchair to the shower and transferred them to the shower chair while the resident was in the shower room.</p> <p>During an interview on 9/25/25 at 8:50 AM, when asked how staff should transport residents to the shower room, the Director of Nursing (DON) stated that she knew the question was in regards to a resident being "drug down the hall backwards" in the shower chair. The DON explained that the Assistant Director of Nursing (ADON) had told her about seeing a staff pull a resident backwards in a shower chair on Tuesday (9/23/25). The DON reported that the staff had not received any official direction and the DON had no expectation for how the staff transport the residents to the shower room. The DON explained her only expectation was that the resident's got their shower. The DON reported the shower room in the 100 hall was not big enough for a mechanical lift, wheelchair and shower chair, and staff would have to use the shower room in the 200 or 300 hallways. The DON explained this could create a problem with staff being able to get all of the residents' showers done.</p> <p>During an interview on 9/25/2025 at 9:07 AM, the ADON reported she saw Staff A, CNA, pull a resident in a shower chair backwards down the hail. The ADON reported staff should not pull people down the hallway backwards, and explained this was a dignity concern. The ADON reported she provided education to Staff A, CNA. The ADON reported she reminded Staff A to take the residents in a wheelchair to the shower room and transfer them to the shower chair in the shower room. Remind to take in a w/c to the shower and transfer them</p>	F0550		

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F0550 SS = D	Continued from page 4 there. Review of an undated facility policy, titled Shower Policy, directed the staff to take the residents to the shower room, remove the residents' clothing and transfer them to the shower chair in the shower room.	F0550		