

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/30/2024
NAME OF PROVIDER OR SUPPLIER  Valley View Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2571 Guthrie Avenue Des Moines, IA 50317	

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)
<p>F 0741</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990</b></p> <p>Based on direct observation, clinical record review, staff interviews, family interviews, and policy review, the facility failed to provide sufficient amount of properly trained staff to implement care plan interventions for 1 of 1 residents with self-injurious behavior. (Resident#37). The facility staff also failed to intervene when the resident displayed behaviors. This resulted in harm to the resident in the form of three occurrences of cellulitis and loss of the distal portion of the left index finger - the tip of the left index finger to the first finger joint. She was placed on antibiotics for the treatment of the cellulitis. The facility reported a census of 75.</p> <p>Findings include:</p> <p>Record review of Resident #37's Minimum Data Set (MDS) assessment dated [DATE] documented that a Brief Interview of Mental Status (BIMS) could not be completed due to the resident being rarely or never understood. The MDS also documented the need for significant assistance for transfers, dressing and toileting, supervision at meals with set up assistance, and assistance for bed mobility. The resident's diagnoses included, non-traumatic brain dysfunction, Alzheimer's disease, Non-Alzheimer's Dementia, diabetes, anxiety, depression, and pain.</p> <p>Record review of Resident #37's Care Plan last revised on 05/17/24 indicated staff should redirect self-harm behaviors by handing Resident #37 something to eat or giving her a stuffed dog. It indicated dependent care for oral hygiene.</p> <p>Review of oral hygiene charting revealed that oral cares were only recorded as completed on the following dates and times:</p> <ol style="list-style-type: none"> <li>1. 04/29/24 at 10:52 AM</li> <li>2. 04/30/24 at 12:24 AM</li> <li>3. 05/07/24 at 02:48 PM</li> <li>4. 05/08/24 at 09:23 AM</li> <li>5. 05/09/24 at 04:25 AM</li> </ol> <p>(continued on next page)</p>

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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<p>F 0741</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>6. 05/10/24 at 12:35 PM</p> <p>7. 05/11/24 at 03:55 PM</p> <p>8. 05/12/24 at 10:21 AM</p> <p>9. 05/13/24 at an undocumented time.</p> <p>Review of a Physician's Progress Note dated 04/15/24 revealed the following:</p> <ol style="list-style-type: none"> <li>1. Resident #37 had a diagnosed history of advanced dementia.</li> <li>2. She was placed on hospice services.</li> <li>3. She had been persistently biting at her nails and fingers, ongoing for approximately two months as of the date of this progress note.</li> <li>4. It began as minor wounds, but the patient had now chewed off the distal part of the left index finger near the distal interphalangeal (DIP) joint.</li> <li>5. She had dementia related agitation, anxiety, and hallucinations.</li> <li>6. The care team added Divalproex Sprinkles 125mg twice daily on 03/25/24.</li> <li>7. This was reported to have slowed her behaviors, but staff reported finger chewing worsened as of the writing of this progress note.</li> <li>8. Other measures have failed to stop chewing, included bandages and gloves.</li> </ol> <p>The Progress Notes for the resident documented the following:</p> <ol style="list-style-type: none"> <li>a. On 02/07/24 at 05:24 AM the resident was agitated, yelling, and biting an open area on the middle finger of the left hand. The area appeared swollen, red, and painful. The area was cleansed and covered.</li> <li>b. On 02/07/24 at 12:45 PM the resident was seen by the physician's assistant (PA) for an acute visit in which the resident presented with a swollen finger. The resident was prescribed Keflex 500mg two times daily for ten days, the wound to be covered, and triple antibiotic ointment to be applied to the left middle finger.</li> <li>c. On 02/12/24 at 07:31 AM the resident remained on antibiotics for cellulitis of the left middle finger. Resident #37 continued to bite at the area, and had removed the bandages, but fresh bandages were applied. It noted a scant amount of serosanguinous drainage present on the dressing.</li> <li>d. On 02/24/24 at 05:48 PM The resident continued to bite at her left index finger.</li> <li>e. On 02/25/24 at 06:23 AM The resident bit her left index finger nail causing mild bleeding.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/30/24 at 09:06 AM A family member of Resident #37 stated he feels the facility does not have enough staff to adequately care for all of the residents in the Memory Care Unit. He noted when a resident is being assisted it often leaves only one person to watch the entire floor. He noted he visits every morning and most evenings. The family member gave permission to take pictures of Resident #37's fingers. These pictures were taken on 05/30/24 at 01:05 PM. They revealed scabs on the distal phalangeal joint, with a finger missing above that point on the left index finger. The fingernail of the middle left finger had been removed and there was an open wound with a small white area protruding from the nail bed. There was recent trauma to the proximal phalangeal joint present with some scabbing noted.</p> <p>In an interview on 05/29/24 at 4:46 PM The Director of Nursing (DON) acknowledged the expectation is for nursing staff to attempt redirection as soon as they witnessed the self-injurious behavior. She noted kitchen and activities staff are expected to say something to nursing staff when they witness the behavior so that nursing staff can attempt to implement interventions in accordance with Resident #37's care plan. She stated she did not believe the facility could provide one on one care for Resident #37 at this time.</p> <p>Review of a visual body inspection dated 05/24/24 documented that the resident had no new injuries or damaged skin present.</p> <p>Review of a facility document titled Behavioral Health Services last reviewed on 03/18/24, documented the facility's interdisciplinary team (IDT) will evaluate behavior health symptoms to determine the degree of severity, distress and potential safety risk to the resident and effectiveness of interventions. If necessary, safety strategies will be implemented immediately to protect the resident or others from harm. If a resident is having behaviors that are not responding to current interventions, staff will complete a behavioral expression-elevated event and this will be reviewed by the IDT. Facility staff will receive education to ensure competency in meeting the behavioral health needs of residents.</p> <p>Review of a facility document titled Dementia Care last reviewed on 03/28/24, documented the facility will use consulting psychologists as needed for assessment and intervention, and should it be deemed necessary for the well-being of the resident, safety of other residents, and/or staff, the use of geriatric inpatient mental health units. The facility did not provide evidence that this occurred.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50471</p> <p>Based on observation, staff interview, and facility policy review, the facility failed to place a barrier prior to performing blood glucose monitoring for 3 of 3 residents reviewed (Residents #13, #26, #55), additionally the facility failed to have a sharp container when needed by staff for 3 of 3 residents (Residents #13, #26, #55), and the facility failed to properly locate the accu monitor while being cleansed by disinfecting wipe while using the same monitor for 3 of 3 residents (Residents #13, #26, #55). The facility also failed to follow infection control during dining service. The facility reported a census of 75 residents.</p> <p>Findings include:</p> <p>Observations revealed the following:</p> <p>a. On 5/28/24 at 11:25 AM, staff placed blood glucose items on surface without barrier, staff did not place lancet in sharp container after use, and staff wrapped blood glucose monitor with disinfecting wipe and placed it in the tray with clean blood glucose items.</p> <p>b. On 5/28/24 at 11:28 AM, staff placed blood glucose items on surface without barrier, staff did not place lancet in sharp container after used, and staff wrapped blood glucose monitor with disinfecting wipe and placed it in the tray with clean blood glucose items, used the same monitor from previous resident.</p> <p>c. On 5/28/24 at 11:33 AM, staff placed blood glucose items on surface without barrier, staff did not place lancet in sharp container after used, and staff wrapped blood glucose monitor with disinfecting wipe and placed it in the tray with clean blood glucose items, used the same monitor from previous resident.</p> <p>On 5/30/24 3:11 PM, The Director of Nursing (DON) reported staff should be using a paper towel or a barrier, sharp container is located on the medication cart, each resident has their own monitor that is stored in their own bag, and monitor should be on a barrier on the med cart to allow to dry.</p> <p>The facility policy title Blood Glucose Monitoring-Assure Prism revised 3/28/24 included the following documentation:</p> <p>Number 2- Gather the following equipment: test strips, glucose monitor, lancets, cotton balls, sharps container.</p> <p>Number 3- Place equipment on a clean barrier.</p> <p>The facility policy titled Clean-disinfect glucometer revised 7/24/23 included the following documentation:</p> <p>Policy statement- This glucometer is disinfected after use and stored in designated location.</p> <p>Number 1- Each resident's glucometer will be stored individually.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Number 2- Clean per manufacturer's instructions.</p> <p>Number 3- Store individual glucometers in Ziploc bag or similar to keep separated from other machines.</p>