STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165507	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Village	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46873 Based on observation, clinical record review, staff interview, and facility policy review, the facility failed to ensure the safety for 1 of 5 residents (Resident #2) reviewed. This failure caused harm when Resident #2 was improperly transferred and needed to be lowered to the floor. This transfer resulted in a ligament injury. The facility reported a census of 72 residents. Findings include: The Annual Minimum Data Set (MDS) of Resident #2, dated 11/18/24, identified a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS revealed the resident required substantial/maximal assistance for sit to stand, chair/bed-to-chair transfers and toilet transfer. The MDS documented diagnoses that included osteoporosis and Alzheimer's Disease. The MDS recorded the resident had not received any scheduled or as needed pain medication during the prior five days, and denied having any pain. The resident denied having had any pain during the prior 5 days of the look back period. The following Significant Change MDS Assessment for Resident #2, dated 1/23/25, revealed the resident was now totally dependent on staff for sit to stand, chair/bed-to-chair transfers and toilet transfer. The MDS documented the resident received scheduled pain medication and non-medication interventions for pain. The resident reported she had pain during the prior 5 days of the look back period. The Care Plan of Resident #2 identified a problem area needing assistance with daily needs. It directed staff the resident required two staff members for transfers, dated 8/12/24. On 1/6/25, the Care Plan was updated to require the resident to transfer with a standing mechanical lift from her bed to her wheelchair only. The Care Plan was updated again on 2/7/25 directing the staff to use two staff members using a full body mechanical lift for transfers. The resident was receiving Physical Therapy at the facility and was seen on 11/18/24. The Physical Therapy Treatment Encounter note documented the following; Patient completes sit to stand transfers from wheelchair to four wheeled walker with minimal to moderate assist each time. Patient requires extensive cues for upright posture and full bilateral knee extension. The note did not detail the resident experiencing any pain in either leg. (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 11/19/24 documented staff reported to the Registered Nurse the resident had fallen. Upon assessment, the resident was found to be in a sitting position on the floor with her legs stretched. Staff reported the resident had started to fall and was lowered to the floor, and during the lowering, her right knee had bent. The resident was complaining of severe pain, and was unable to move or bend her right leg. The medical provider was notified and the facility received orders to send the resident to the emergency room (ER) for evaluation. The ER notes documented the following: Musculoskeletal exam: Swelling, tenderness, and signs of injury present. Right upper knee: Swelling and bony tenderness present. Decreased range of motion. Tenderness present over the medial joint line. Right upper leg: Tenderness present. No swelling, deformity or bony tenderness. Comments: Limited range of motion right lower extremity. - Findings: Ligamentous injury versus knee sprain. Knee immobilizer was avoided due to risk of pressure induced soft tissue injury due to age and lack of subcutaneous tissue. Placed in an ACE wrap. Non weight bearing at baseline. The Event Report dated 11/19/24 documented the resident received an injury to her right lower extremity, experiencing painful/limited range of motion. Her left lower extremity was documented as strong movement, and her right lower extremity was documented as weak movement. The Report documented the operational factors which led to the fall as Students transferred resident without gait belt and proper transfer. Lowered to floor. The written statement from Student #1 documented the Student went to answer the resident's call light and the resident stated she needed to use the restroom. The student retrieved the wheelchair and moved it next to the recliner. The statement documented the resident told the student that she could do it (stand up) on her own, but the student offered help by holding her hands, then moving into a hug position to lift the resident but she was unable to lift her alone. The student documented that she then called for a second person (Student #2). She wrote they tried to move the resident to her wheelchair but the resident had started calling out about her leg, so she attempted to move the resident back to her recliner and for extra help. She documented the resident was still complaining of her leg and she then noticed the resident's right leg was caught by the wheel of the wheelchair. At that time, the students lowered the resident to the ground, writing that because of the position of her right leg behind her bent at the knee, they were not able to lower her fully to the ground. Staff A, Certified Nurse Aide (CNA) entered the room to help support the resident to a safe position. The statement ended with noting the resident was complaining of right knee pain. The written statement from Student #2 documented she was in the hallway and heard Student #1 calling for help. Her statement noted the resident was unbalanced and leaning forward almost off of the recliner, so she and Student #1 attempted to move the resident to the wheelchair. The resident's right foot was caught on the wheelchair wheel and she was unable to stand. She wrote they then lowered her to the ground and her right knee was under the resident's buttocks. The two students called for help and Staff A, CNA came to assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The written statement from Staff A, CNA documented she was alerted by students of needing help in Resident #2's room, and heard Resident #2 calling out before she got to the room. She wrote the students had attempted to transfer Resident #2 and had not used a gait belt. The students were attempting to hold the resident up and she instructed them to lower her to the floor. She stated when she asked the students what happened, they told her the resident needed to use the restroom, and they had positioned the wheelchair close to the resident and attempted to assist her due to the resident stating she could do it herself. The Medication Administration Record (MAR) of Resident #2 for November of 2024 documented an order for Hydrocodone-Acetaminophen 5/325 mg (a narcotic pain reliever mixed with acetaminophen/Tylenol) ordered to be given one tablet three times a day beginning 11/20/24. The MAR reflected the order was changed on 11/25/24 to a half tablet three times a day. The MAR reflected additional orders for an ice pack to the right knee for 20 minutes at a time as a non pharmacological pain intervention. The MAR for March of 2025 revealed the current pain medication order to be Hydrocodone-Acetaminophen 5/325 mg, half a tablet, four times a day. Review of Progress Notes of Resident #2 identified the following: 11/20/24: Returned to facility on a stretcher via ambulance accompanied by two male staff. Transferred into her bed with assist x 4 without difficulty. Resident wakened during transfer from stretcher to bed and began crying out: Please leave me alone, please don't touch my leg it hurts. 11/20/24: Lying in bed resting soundly with eyes closed, no further crying out in pain after PRN Tramadol. She did refuse the scheduled ice pack to right knee yelling: stop it, no, I don't want it, leave me alone! 11/21/24: Resident has been resting quietly this shift without complaints voiced when lying still. Nurse placed pillow under legs to float heels which resident did wince at. Routine Norco (Hydrocodone/Acetaminophen) initiated with resident sleepy. 11/21/24: Patient has been in bed all shift again today. Did drink and eat better and her pain seems to be in better control. Cold pack applied several times to her right knee, patient tolerated well. Therapy was in and stated to use the Hoyer (full body mechanical) lift for resident when she gets up. 11/26/24: Removed ace wrap and floated heels on pillow. Ice three times a day continues. Right lower extremity remains edematous and resident has pain with movement and repositioning. 11/27/24: Continues to use Hoyer lift assist of two for transfers 11/30/24: Resident up in wheelchair this evening. Voiced no complaints of pain but did show symptoms during transfer to bed via Hoyer lift. 12/2/24: Hospice referral sent. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/5/24: Resident denies complaints of pain unless she is moving. Assist of two with Hoyer lift for transfers. Ice, norco and ace wrap continue for swelling and pain issues. 12/13/24: Family requested decrease in pain medication due to resident being too sleepy 12/15/24: Edema remains to bilateral lower extremities, right greater than left. Assist of two via Hoyer lift for transfers 12/16/24: Staff requested to reinstate order for ice pack as an as needed order. Resident remains on scheduled narcotic pain medication four times a day which appears to manage pain at this time. Remains as a two person assist with a full body mechanical lift for transfers. Resident #2 was observed on 3/4/25 at 12:17 being transferred from her bed to her wheelchair by Staff B, CNA and Staff C, CNA. The full body mechanical lift sling was in place under the resident as she laid in bed. Staff B and Staff C secured the loops of the sling to the mechanical lift, verified placement and safety, and appropriately transferred Resident #2 from the bed to her wheelchair. Resident #2 stated during the transfer this leg hurts and indicated with her hand it was her right leg hurting. Observation ended after the resident was safely in her wheelchair, foot pedals were put in place, and staff was fixing her hair prior to taking her to lunch. On 3/4/25 at 4:57 pm, the Administrator stated the CNA students had been provided with pocket care guides. She said the students were eager to help and the resident told them it was fine. The Administrator verified the resident was care planned as a two staff assist but the students failed to use a gait belt. On 3/5/25 at 8:42 am, the Assistant Director of Nursing stated the resident only had the single injury to her knee in November of 2024 but has always had pain in her knee. On 3/5/25 at 9:29 am, the Physician Assistant from the facility stated the injury was a potential ligament injury. She stated due to the resident continuing to complain of pain, she did order a second x-ray (results were negative for any fractures). She stated the family ultimately chose to pursue hospice care as she had been declining prior to the injury related to advanced age and her diagnosis of Alzheimer's Disease. She stated she feels the resident's right leg pain will always be chronic and they are treating it as much as possible to keep her comfortable. Her pain management regimen has changed a couple of times to try to give the most pain relief without causing sedation or other side effects. On 3/5/25 at 1:17 pm, Staff A stated when she entered the room, the resident was not yet lowered to the floor. She described the resident's left leg as being extended forward and her right leg was bent. Staff A stated she instructed the students the resident needed to be lowered to the floor. When she was lowered, due to her leg being bent, her right leg was going out to the side but underneath the resident as she was gently lowered. She stated the resident was either wearing tennis shoes or slippers with non slip grippers on them. She stated the students were not using a gait belt during the transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility policy Transfer/ambulation assist using gait/transfer belt, review date 3/25/24 documented the following: Policy: Gait/transfer belts will be used for all residents who require physical support for mobility or safety in transfers. The residents will be assessed for appropriate transfer status by PT, OT, or a nurse. Gait/transfer belt will be removed upon completion of transfer/ambulation. Follow care plan for number of staff assistance required. Procedure: Assist to stand 1. Identify resident. 2. Verify in care plan the number of staff required for transfer assistance. 3. Explain procedure as needed. 4. Provide privacy as needed. 5. Apply the gait/transfer belt snugly around the waist, over the clothing. Apply the belt snugly enough so it will not ride up or down on the resident's body. 6. Fasten the safety buckle in the front, slightly off center. 7. Bring the resident to a standing position, using one or two hands on the gait/transfer belt. Do not lift resident under their arms during transfers. If the belt loosens, tighten it again after the resident is standing.