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No. 0938-0391

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	04/30/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on clinical record review, staff interview, and policy review, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) evaluation as required for 1 of 3 reviewed (Resident #83). The facility reported a census of 76 residents. Findings include:Resident #83's Electronic Health Record (EHR) profile documented an admission date of 4/22/26. Resident #83's progress note dated 4/22/26 at 4:32 PM documented the resident admitted to the facility from the hospital. Review of #83's EHR lacked documentation of a PASRR completed.On 4/28/2026 at 8:55 AM Received Resident #83's PASRR from the Administrator. Review of the PASRR noted Staff A completed it on 4/27/26. During an interview on 4/28/2026 at 1:25 PM Staff A, Hospital Liaison/Admissions Coordinator reported the hospital usually does the PASRR. Staff A reported last night she received a phone call on Resident #83's PASRR not in the chart. Staff A reported she completed the PASRR last night Staff A reported she missed it prior to admission and it should have been done. During an interview on 4/28/2026 at 1:37 PM the Administrator reported the facility receives the PASRR from the hospital admission records and it is to be completed prior to admission to the facility. She reported Resident #83's PASRR was missed somehow and not complete prior to admission.

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview and policy review, the facility failed to ensure a resident was properly positioned and placed in an upright position in order to facilitate consumption of beverages and food and to reduce the risk of choking and aspiration during 1 of 2 mealtime observations. (Resident #31) The facility reported a census of 76 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnosis of Alzheimer's Disease. The resident had a Brief Interview for Mental Status score of 2, indicating severely impaired cognition. The MDS indicated the resident required partial to moderate assistance for eating. The Care Plan initiated on 4/18/25 revealed the resident had a nutrition and hydration risk related to an end-stage diagnosis, cognitive limitations and weakness. The Care Plan directed staff to provide a general diet and thin liquids, and provide assistance with eating. During dining observations on 4/28/26 starting at 8:22 AM in the Magnolia Unit revealed Resident #31 sat in a broda chair with the broda chair reclined back. At 8:41 AM, the dietary aide placed food on the table in front of Resident #31. At 8:43 AM, Staff D, certified nursing assistant (CNA), placed beverages and food on an overbed table for Resident #31and walked away. At 8:47 AM, Resident #31 continued to sit in a broda chair with her eyes closed and a plate of food in front of her that was untouched. At 8:48 AM, Staff E, CNA, picked up a glass of chocolate milk and offered Resident #31 the chocolate milk. The broda chair remained tilted backward. Resident #31 struggled to move her head up and forward to get her mouth up to the cup. Staff E then offered Resident #31 hot cereal but the resident said later. At 8:53 AM, Staff D, CNA, offered Resident #31 a drink of chocolate milk. The broda chair remained in the tilted back position. In an interview on 4/30/26 at 10:55 AM, the Director of Nursing reported the facility had no policy for positioning. The staff would get education about positioning during facility training and the CNA certification training. The DON reported she expected residents to be placed in an upright position whenever food or drink offered. A Feeding of Residents by Staff policy reviewed 2/18/26 revealed residents unable to feed themselves will be provided with assistance per their care plan. The resident shall be positioned comfortably in an upright position.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews and policy review the facility failed to provide adequate supervision to prevent an elopement for one of three wandering residents reviewed (Resident #79). The facility also failed to answer resident call lights within the allotted professional standard of 15 minutes for 3 of 5 residents reviewed (Resident #28, #83, and #84). The facility reported a census of 76 residents. Findings include: 1.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 had diagnoses of Alzheimer's Disease, bipolar disease and anxiety disorder. The MDS recorded the resident had a Brief Interview for Mental Status of 9, indicating moderately impaired cognition. The MDS documented the following related to walking; resident used walker, when walking 150 feet the helper provides verbal cues and/or touching/steadying and /or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. The MDS documented the resident exhibited no wandering behaviors. The Residents Care Plan had a start date of 2/11/26 and revealed Resident #79 had Alzheimer's Disease and dementia. The Care Plan identified that the resident had a risk for elopement due to wandering. The resident ambulated independently with a wheeled walker. The Care Plan directed staff to redirect the resident as he allowed and ensure his needs were met. An approach for staff was added on 3/14/26 to do frequent checks and monitor his whereabouts. Progress Notes revealed the following: a. On 3/6/26 at 9:40 PM, resident had agitation, aggression, and restlessness before dinner. Non-pharmacological alternatives such as redirection, explanation of situation such as dinner is on the way, and a calm approach were not effective. b. On 3/14/26 at 3:00 PM, after the AM meal, resident made the following speech in the dayroom: This is a place of refuge for slaves and criminals. This is a wonderful Christmas season for our refugees. Congratulations to this choir for singing beautiful Christmas songs with beauty and great expression. Thank you all. c. On 3/14/26 at 6:58 PM (recorded as a late entry on 3/16/26 at 1:44 PM), Staff G, Licensed Practical Nurse (LPN) documented that Staff H, Registered Nurse (RN), escorted the resident back onto the unit at 6:00 PM. It was discovered that the resident had left the unit through the back exit. The door alarm was sounding. A CNA returned to the alarming door. Resident was assessed. Family, physician and management was notified. Upon camera footage review, the resident was outside approximately 3 minutes and escorted back by staff. The weather was 52 degrees. The resident was dressed appropriately. Staff education was provided immediately and an elopement protocol was implemented. The Incident Summary revealed Resident #79 had a BIMS of 4, indicating severely impaired cognition. On 3/14/26 at approximately 5:55 PM, the back exit door alarmed on the Memory Care unit. Staff I, certified nursing assistant (CNA) responded. Five minutes later, at 6:00 PM, Staff H, RN, walked Resident #79 back onto the unit and stated the resident was in the back parking lot (which is located off the back exit door). The resident walked independently with a walker and appeared in good health. Resident was assisted to the recliner and assessed. Upon investigation, the resident left the dining room at approximately 5:53 PM, walked down the hallway and then later walked through the alarmed door to the back parking lot. Resident #79 was out of site for approximately five minutes. The Facility's Investigation revealed the following:a. The census on the Memory Care Unit was 17 residents. b. The weather was 52 degrees, the sun was out and there was no inclement weather.c. Resident #79 had long pants, a long sleeve t-shirt and grippy socks on. d. On the evening of 3/14/26, Staff J, CNA, Staff I, CNA, and Staff G, LPN, worked on the unit. Supper was served at approximately 5:15 pm. All residents were in the dining room with staff, and the TV was on. After Resident #79 finished eating his meal, he arose from his chair to walk the hall independently with his walker as he normally did. e. Resident #79 often demonstrated continuous pacing/wandering within the unit and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had not previously shown any signs of exit seeking such as testing doors or approaching exit areas. Resident #79 went all the way down the hall and back several times, as shown by the video surveillance. At approximately 5:42 PM, Resident #79 was at the back of the hall at the furthest point from the dining room and went by the emergency exit door. The emergency exit door has a 15-second egress and an alarm, both of which were working. The staff could not hear the alarm due to the noise level in the dining room at the time. Resident #79 pushed the bar on the side of the door by the hinges, which also prohibited the door from opening, and in doing this, he held the bar on the door down for 15 seconds, releasing the 15-second egress. At this point, he pushed on the other side of the door and was able to push it open. Through this door is a floor-level exit door to the employee parking lot. At approximately 5:43 PM, Resident #79 was shown by video surveillance exiting the door on the walkway by the employee parking lot. As he is exited, Staff H arrived to work and was seen driving by the resident and then parked in the lot. Staff H immediately went over to talk to Resident #79 and helped escort him back into the building. Staff H and Resident #79 was seen walking together from another video camera at approximately 5:45 PM. Per video surveillance, at approximately 5:48 PM, Staff H and Resident #79 was seen entering the building together. They then walked together back to the Memory Care hall, where Resident #79 was assessed. His overall appearance was stable and in good condition. Immediate intervention included increased checks and redirection to activities. In an interview on 4/28/26 at 8:30 AM, Staff K, certified medication aide (CMA), reported Resident #79 was pleasantly confused, an intelligent man and very funny. He was independent and used a walker. Staff K reported she was not working on the day Resident #79 left the unit. Staff K reported there were alarms on all of the doors in the unit. Staff K reported they had to push on the bar on the door for 15 seconds before the door would open. There were alarms on all of the exit doors and required a code to be entered in order to go through the door or stop it from alarming. Staff K reported she had not ever seen Resident #79 try to push the exit doors open. In an interview on 4/28/26 at 4:51 PM, Staff I, CNA, reported she recalled the facility staff went over alarms and where the alarms were located during her orientation. The alarms were located at each exit door on the front, side and back hall exit door. Staff had to hold the door for 15 seconds and then the door could be opened. Each door had a different code that could be entered to stop the alarm. Staff I reported Resident #79 had behaviors and often wandered around the unit. Resident #79 ambulated with a walker. On the day Resident #79 left the unit, there were only 2 CNA's working on the unit and they were in the dining room feeding 6 to 7 residents. Resident #79 cannot sit for two seconds. Resident #68 was also having behaviors that day. Staff I told Resident #79 to sit down and he sat down in a chair. While Staff I assisted the residents in the dining room, Resident #31 had spilled her chocolate milk. Staff I got some towels and cleaned the milk up. When she got up from the floor, she did not see Resident #79. As she carried the soiled towels, she saw Staff G. Staff G told her they were looking for Resident #79. As they walked by the nurse's station they heard the alarm coming from the back hall exit door. Staff I went to the door and punched in the code to stop the alarm. They did a count of the residents and that was when Resident #79 was being brought into the building. Staff I reported it was within seconds from the time she noticed the resident not in the dining room to when she noticed the alarm going off and Resident #79 being brought into the unit by Staff H. In an interview on 4/29/26 at 7:28 AM, Staff L, RN, reported Resident #79 had not walked in weeks while he was at the hospital but when he got to the facility he started walking. Staff had to keep an eye on him. He was only oriented to self. Staff L reported she was not working on the day Resident #79 left the unit. Staff L reported she was aware that Resident #79 had set the alarm off, he got out the back door, and a nurse brought him back to the unit. The back door had an alarm but the alarm on the back door was hard to hear. Staff L reported since the incident they had a monitor, similar to a baby monitor, in the dining room and a monitor on the back door in the stairwell so they could hear the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes. In an interview on 4/30/26 at 10:55 AM, the surveyor asked what the facility had done to ensure a process was in place to prevent further incidents of elopement. The DON responded she had done random checks by setting off the alarm and waiting for staff to respond. She had also checked the monitors to make sure they were plugged in and worked. The DON stated she expected staff to check the alarms and respond to the door, then go through the door to check surroundings and make sure nobody was outside, and do a head count. A Wandering Resident policy reviewed 2/18/26 and revised 3/17/26 revealed the facility ensured that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and received care in accordance with their person-centered care plan. An elopement occurred when a resident left the premises or a safe area without authorization or without necessary supervision. Staff members are to be vigilant in responding to alarms in a timely manner. 2. The Minimum Data Set (MDS) dated [DATE] identified Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented the resident was substantial/maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) for toileting transfer and is dependent (helper does all of the effort. The resident does none of the effort to complete the activity or, the assistance of 2 or more helpers is required for the resident to complete the activity) for toileting hygiene. During an interview on 4/27/2026 at 2:23 PM Resident #5 reported during the meal hour it can take up to an hour for staff to answer the light and had an accident in her pants due to it. During an interview on 4/30/2026 at 11:10 AM the Director of Nursing (DON) reported that the expectation of staff is to answer the call light within the 15 minute time frame. The facility policy for call lights reviewed date 11/20/2025 directed staff it is the responsibility of all staff (from all departments) to respond to the call light and to either assist with the request, if able, or obtain assistance from the appropriate staff to meet the resident's need. 3.Resident #84's Care Plan documented he does not have any cognitive diagnoses, is alert and oriented to himself but occasionally tends to be forgetful. The Care Plan documented he was assisted by 2 staff for transfers. Observation on 4/29/2026 at 7:33 AM Resident #84's call light on. At 7:47 AM Resident #84 heard yelling out from his room for help and the call light was still on. At 7:54 AM Resident #84 yelling out for someone to please help him. Throughout the time staff have been walking the hallway but not answering the light. At 7:58 AM observed staff going into Resident #84's room and answered his light. During an interview on 4/29/2026 at 8:30 AM Resident #84 reported sometimes he waits a long time for his call light and will yell out. He reported it doesn't always happen just in the mornings at times it happens. 4. Resident #83's Care Plan documented he was assisted by 1 staff for transfers. During a continuous observation on 4/29/2026 at 12:54 PM to 1:11 PM noted Resident #83's call light (continued on next page)

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