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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and clinical record review, the facility failed to ensure 1 of 4 residents (Resident #4) review for accidents/hazards, had the appropriate staff assistance for utilizing the elevator, as recommended by therapy. On 9/17/25 at approximately 9:30 AM, Chaplain Assistant supervised as Resident #4 attempted to turn an electric scooter around and exit the elevator independently. The Resident #4 sustained an injury to the lower left leg when the elevator door closed On 9/17/25 at 11:08 AM, following the incident, a Nursing Note revealed that Resident #4's leg was swollen with severe pain. The Resident #4 was transferred to the Emergency Department on 9/17/25 and was found to have a large hematoma to left lower leg. On 4/30/26, the left lower leg hematoma remained unhealed, and Resident #4 continued to complain of severe pain during observation of wound care. The facility reported a census of 76 residents. Findings include: Review of the Minimum Data Set (MDS) assessment, dated 9/12/25, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment. The MDS indicated that Resident #4 was dependent on staff assistance for transfers and cares, Resident #4 was independent in a manual wheelchair for mobility.Review of an Occupational Therapy Note, dated 9/10/25, revealed the following entry: Patient demonstrates the ability to maneuver electric wheelchair with modified independence with the exception of the elevator. Recommendations to be provided upon discharge to upgrade patient to independent with electric wheelchair mobility in facility with assistance to operate the elevator. Review of the Occupational Therapy Discharge summary, dated for service between 8/29/25 and 9/12/25, revealed the goal that Resident #4, family, and/or caregivers would be educated on appropriate recommendations (example: assist levels, equipment) in order to maximize patient independence and safety with Activities of Daily Living (ADLs), mobility, and transfers upon discharge. The Discharge Summary identified that Resident #4 met the goal to be independent in electric wheelchair for mobility, with recommendation to assist with managing doors and buttons in elevator. Review of the Care Plan revealed the Focus area, initiated on 8/21/25 for Mobility: I have been cleared by therapy to be in my electric wheelchair. I have a history of bumping into things which could cause bruising or injury. It is recommended that I only have my electric wheelchair in manual mode for mobility. I am able to use the tilt mode independently with the goal that staff would educate Resident #4 on safe operating as needed through the next MDS assessment. The Care Plan listed an intervention directing nursing discipline to reassess mobility as needed. Review of a facility provided investigation of Resident #4 incident on 9/17/25, revealed the following timeline of events: a. Chaplain Assistant was upstairs guiding people to the chapel downstairs, assisting one person in their manual wheelchair. b. Resident #4 was going downstairs in the elevator. She drove her electric wheelchair into the elevator (car 2), facing the back of elevator. c. When they arrived on the first floor to exit the elevator, Resident #4 told Chaplain Assistant that she could not back up her wheelchair. d. Chaplain Assistant pushed the other resident out of the elevator, who was in a manual wheelchair, and stopped to hold the elevator door open on the side of the door entrance. e. Resident #4 started to turn around in the elevator car to exit, this (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 0689 Level of Harm - Actual harm Residents Affected - Few	took several minutes. Resident #4 then began exiting the elevator and Chaplain Assistant had to move out of the elevator cased opening to let Resident #4 out. In doing this, she removed her hand from the elevator door track opening. f. When Chaplain Assistant removed her hand, the door of the elevator went into nudging mode and began to close. The door came in contact with Resident #4's leg and then immediately began to retract (nudging mode), in normal operation of the elevator, recognizing an obstacle in it's pathway. g. Due to the way Resident #4's legs sit in her electric wheelchair with her knees slightly outward and bent, the door bumped at the top/medial part of the knee. h. Resident #4 verbalized pain and another staff member told Chaplain Assistant to have her nurse look at it. i. Chaplain Assistant noted that her left leg, which was bumped, did not shift and did not bump into her other leg or another object. Resident #4 was wearing pants and had ACE wrap (compression bandages) on. j. Chaplain Assistant brought Resident #4 back up to her hallway and told the nurse what happened. k. Nurse unwrapped Resident #4's ACE wrap that she had up the length of her leg to look at the area that Resident #4 and Chaplain Assistant told her was bumped, and did not see any marks, redness, or bruising, Nurse then rewrapped Resident #4's leg. l. Resident #4 decided she did not want to attend chapel and stayed upstairs on her hall. m. Resident #4 continued to state that her leg hurts. Nurse decided to reassess and unwrapped her ACE wraps. At this time, there was a hematoma that began to swell as the ACE wrap was removed. The ACE wraps were still on the bottom of her leg and on her thigh, which created more pressure at the mid-knee. n. Nurse obtained ice and offered a Per Required Need (PRN) Tramadol (opioid medication used to treat moderate to moderately severe pain in adults) to Resident #4 to help with pain, which Resident #4 accepted. She also asked provider, who was on-site, to look at Resident #4's leg. o. Provider assessed and stated that there was likely no fracture, but to send her out due to the size of the hematoma. p. 911 was called, and Resident #4 was transported to the Emergency Department (ED). Family was present at this time and kept stating that her mom's leg was crushed in the elevator. q. An X-Ray was taken in the ED and there is no fracture. r. Our contracted elevator maintenance is scheduled to evaluate the elevator today due to this incident. The elevator is closed until this occurs. Review of a Nursing Notes, dated 9/17/25, revealed the following entries: At 11:08 AM documented, while resident was going down to church around 9:50 AM, the elevator door closed on her. Resident sustained injury to her left leg. Upon assessment by nurse, resident's leg was swollen and complained of [pain rated] 9 out of 10. One time dose of Tramadol 50 milligrams (mg) given per provider order. Provider was in facility and assessed the resident. Provider gave written order to send out to ED around 10:50 AM of choice for [evaluation]. Resident sent to hospital ED. Family went with her. At 3:58 PM, Resident #4 returned to the facility via stretcher, accompanied by Emergency Medical Technician (EMT) staff with no new orders. Resident's level of pain rated 9 out of 10 on her left lower leg. ED recommended follow up with facility provider in 2 days. On 9/17/25 at 7:29 PM, provider gave telephone order to give Hydrocodone-Acetaminophen (opioid medication used to treat moderate to severe pain) 5-325, 1 tablet every 6 hours as needed for pain.Review of a Provider Visit Note, dated 9/17/25, revealed that Resident #4 was being seen for left leg injury, occurring 5 minutes ago. Patient used electric wheelchair for mobility, was getting onto elevator and elevator door closed onto her left leg. Facility staff were present and report that the door did not close completely but opened back up once it bumped her leg. Door contacted the lateral (side) aspect of the lower leg. The resident had immediate severe pain to the left lower leg, hematoma developed almost immediately. Provider Note documented patient in extreme pain, would not allow for much of an examination. There is a large, softball sized hematoma to left lower leg, just in front and medial to the knee. No open areas/wounds. no obvious bony deformities. Provider indicated that given the severity of pain, opted for evaluation in the ED as opposed to work up at the facility. Resident #4 was transferred via Emergency Medical Services (EMS). Tramadol 50mg x1 given prior to transport. Review of the Hospital ED Note, dated 9/17/25, revealed Chief Complaint for leg injury, Patient was on her scooter at her living facility and her leg got caught in the elevator door. Large hematoma noted on left lower extremity. An X-Ray performed of (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	left tibia/fibula (bone in lower leg) identified no acute fracture or dislocation of left tibia or fibula is apparent. Round subcutaneous mass of the posteromedial (positioned at the back and towards the middle) upper calf, possibly hematoma. Review of additional Nursing Notes, revealed the following documentation, in part: a On 9/18/25 at 7:56 PM, Resident #4 left leg assessed with no new skin issues but remained swollen, hydrocodone 5-325 mg 1 tablet every 6 hours as needed for pain and ice pack administered. b. On 9/19/25 at 12:30 AM, left lower extremity remained swollen and bruised, complained of 10 out of 10 pain, stating that it hurts so bad, as needed pain medication given with bedtime medications and resident positioned in bed until comfortable. c. On 9/21/25 at 6:33 PM, Resident #4 had pain pill x2 today. Ice applied to the left leg and there is a large fluid filled blister. Legs elevated to help with swelling. d. On 9/22/25 at 6:39 PM, Resident #4 complained of pain in left lower extremity. Pain medication and ice pack applied but not effective. Provider notified of condition and telephone order received to send resident out to the ED for evaluation.Review of a Hospital Discharge summary, dated [DATE], revealed reason for hospitalization related to hematoma and acute metabolic encephalopathy (brain dysfunction caused by systemic illness, organ failure, or toxic substances that can disrupt normal metabolism, leading to altered mental status, confusion, and sometimes coma). Hospital Course indicated admission on [DATE] with acute metabolic encephalopathy and left lower extremity hematoma/pain following injury from an elevator on 9/17/25. Encephalopathy improved over 24-48 hours. Surgery consulted for evaluation of left lower extremity hematoma, discharge with orthopedics and receiving wound cares. Lower extremity venous ultrasound on 9/23/25 negative for Deep Vein Thrombosis (DVT or clot). Pain has improved and will require several more days of oxycodone (strong prescription opioid medication used to treat moderate to severe pain) 2.5 mg every 6 hours as needed. During an observation on 4/29/26 at 8:12 AM, Staff O, Certified Nursing Assistant (CNA), assisted Resident #4 onto the elevator by manually pushing the scooter from behind. Resident #4 asked Staff O if she would go with Resident #4, Staff O told Resident #4 yes, you do not go by yourself. Resident #4 stated that she got her leg struck and asked Staff O to watch her feet when entering the elevator. Resident #4 stated that her leg had hurt since September. During an interview on 4/30/26 at 9:40 AM, Resident #4 stated that she continued to have pain in left lower leg following the incident in which the elevator door bumped into her leg. During an observation on 4/30/26 at 9:44 AM, Staff C Registered Nurse (RN) performed wound cares to Resident #4's left lower leg wound. Staff C removed the old dressing that appeared to be heavily saturated and dripping serosanguineous (mixture of blood and serum, usually thin watery drainage that is pink or yellow in color) from the dressing onto the floor as Staff C disposed of it. The wound to left lower extremity appeared to be approximately the size of a softball, the wound bed appeared red in color and actively bleeding bright red blood following the dressing removal. Wound edges from approximately 2'o'clock to 6'o'clock were rolled under. Resident #4 winced, gasped, and said ow with touch to the wound throughout the procedure. Staff C cleansed the wound bed with normal saline, then patted dry with gauze, applied treatment and covered with new adhesive padded dressing. During an interview on 4/30/26 at 12:26 PM, Staff P, Physical Therapist (PT) stated that on 9/12/25 mobility recommendations indicated that Resident #4 would require nursing or CNA assistance to assist with elevator doors and buttons when traveling on elevator. Staff P reported that therapy department communicates recommendations to the nursing department via email for the floor nurses and CNA staff to update the resident's plan of care. Staff P identified that an email was sent out to nursing staff that this was the recommendation for Resident #4 on 9/12/25 and that the therapy department received communication from the Interdisciplinary Team (IDT) on 9/17/25 that Resident #4 was no longer allowed to drive electric scooter independently due to incident with injury and instruction to use manual mode. During an interview on 4/29/26 at 1:59 PM, Chaplain Assistant recalled that on 9/17/25 when assisting residents to the chapel for an activity, Resident #4 went into the elevator using electric scooter. The Chaplain Assistant stated Resident #4 didn't seem too comfortable using the electric scooter so she entered the elevator as well, while pushing another (continued on next page)

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 0689 Level of Harm - Actual harm Residents Affected - Few	resident in a manual wheelchair. The Chaplain Assistant reported pushing the other resident's wheelchair out of the elevator upon arrival to the first floor, and due to being previously informed not to block the elevator for too long, stood outside of the elevator and waited for Resident #4 to exit the elevator. The Chaplain Assistant stated that Resident #4 took a long time to get electric wheelchair turned around in the elevator and as she was coming out, the elevator door shut and hit Resident #4's leg and Resident #4 immediately complained of pain to the leg. The Chaplain Assistant recalled taking Resident #4 back upstairs on the elevator to the nurse who assessed Resident #4's leg. During an interview on 4/30/26 at 3:25 PM, Staff Q, CNA, stated she had been employed by facility for approximately 5 years and was familiar with Resident #4. Staff Q recalled that Resident #4 would not be safe to maneuver her electric scooter independently in the elevator due to a history of bumping the scooter into things. Staff Q denied knowledge of any guidance received for who could help or how to assist Resident #4 with using the elevator but recalled that an incident with injury that involved the elevator is why Resident #4 was changed from independent to manual mode when using the electric scooter. During an interview on 4/30/25 at 4:54 PM, Staff F, Certified Medication Assistant (CMA)/CNA stated she had been employed by facility for approximately 2 years and was familiar with Resident #4. Staff F denied knowledge of guidance received for who could help or how to assist Resident #4 with using the elevator but recalled that following an incident with the elevator, Resident #4 was unable to use the electric scooter independently. During an interview on 4/29/26 at 12:34 PM, the Director of Nursing (DON) stated that the previous facility Administrator had investigated the incident. The DON reported that in response to the incident, the facility had an elevator technician come onsite to ensure proper elevator operation and Resident #4 no longer used her electric wheelchair independently. During an interview on 4/30/26 at 2:01 PM, the previous facility Administrator confirmed that therapy would send out an email of recommendations to the nursing staff, which would be put into a resident's plan of care. The previous Administrator stated that therapy had assessed Resident #4, and determined she could be independent in the electric scooter. The previous Administrator denied clarification with therapy on Resident #4's recommendations for elevator assistance, but said Resident #4 could not reach the buttons in the elevator, and stated that anyone could help with this. The previous Administrator confirmed that elevator technicians evaluated the elevator for safe operation as intervention following the incident involving Resident #4.

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 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)

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 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)

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sounds from the back exit door over the monitor. On 4/29/26 at 7:32 AM, Staff L, RN, reported the back door was an exit for fire safety purposes and was not used as an entrance or exit to the facility routinely. The back door led to the stairwell and then to another exit door to exit the building. The outside exit door led to the parking lot. On 4/29/26 at 10:05 AM, the DON reported the facility had cameras located at the entrance to the facility, in the hallway (of the unit) by the exit doors, and another camera to the outdoor exit door. The DON provided video footage of the incident involving Resident #79 on 3/14/26. The surveyor viewed three different cameras: 1 in the unit by the DR and exit door, 1 by the back exit door to unit and 1 by the back exit door to the outside. Video #1 on 3/14/26 starting at 6 PM (video was 2 minutes long) revealed resident ambulated in the hallway with a four wheeled walker and went by the exit door. He stopped to look at the scale in an alcove, then proceeded to walk across the hall to the exit door. Camera footage revealed the resident stood by the door for a period of time and then breached the door to open it. He then proceeded to walk through the door, and the exit door closed. Video #2 on 3/14/26 at 5:42 PM (video was 1 minute long) revealed resident came through the back exit door to the outside and ambulated down the sidewalk to the driveway toward the parking lot with his walker. From the start of the video to the time the resident exited the back door was 41 seconds. A van was viewed pulling into the driveway and parking in the parking lot.Video #3 on 3/14/26 at 5:46 PM (lasting 1 minute, 21 seconds) revealed a female walked up to the resident as the resident walked with the walker, and then the female ambulated with the resident toward the sidewalk and into the building. The DON reported Resident #79 typically ambulated with a walker around the unit but this was the first time he had exited the unit. On that day, it was during mealtime, there was a lot of residents and staff in the dining room. There was a lot of noise with people talking and the TV was on. Staff did not hear the alarm sounding. Family was notified about the incident and staff increased their monitoring of the resident. The resident did not have any kind of injury or fall at that time. The DON reported since the incident, they put in a monitor by the back door and the dining area so staff could hear the alarm or anything going on by the back exit door. They also did an elopement drill with all of the staff. Elopement drills were unannounced and held quarterly on different shifts. In an interview on 4/30/26 at 7:29 AM, Staff J, CNA, reported she had worked at the facility three months. Resident #79 had dementia and had behaviors. He wandered all of the time and staff had difficulty getting him to sit down. Staff had to follow him around. On the day of the incident, Staff J reported she kept redirecting Resident #79 to sit in the dining room. It was suppertime and residents were eating. She had just sat him down in the dining room, and when she looked again, she saw Staff H bringing him into the unit. At that time, she wondered why or what was going on. Staff G and Staff I went down and found the alarm by the back exit door sounding. Staff J reported she did not hear the alarm going off. Staff J was in the dining room talking with residents and assisted residents with feeding. After Resident #79 was brought to the unit, she went and checked to make sure everyone was in the unit. Staff J reported the door the resident went out is not used as an entrance to get in and out of the building. Staff J felt the facility had enough staff on the unit but it also depended on the residents and what was going on, such as if residents were sundowning or had behaviors. In an interview on 4/29/26 at 10:58 AM, Staff G, LPN, reported she worked the evening shift on the day of the incident with Resident #79. They had enough staff but Resident #79 was very quick. In the Memory Care unit, a resident will be is one place one minute and the next minute they move. On that day, Resident #79 took off with his walker. Staff H came in the front door and had Resident #79 with her. Staff H brought Resident #79 to the unit. Staff G reported she checked him over. The resident had shoes on, and the weather was not too cold or too hot. Staff G explained that there was an alarm that went off. As the CNA walked toward the lobby, the alarm was faint from the day room. The CNA checked it over and cancelled the alarm. At the time, Staff G reported she was standing in the dining (continued on next page)

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room assisting a resident with feeding. Resident #79 was in the dining room at that time. Staff G stated she may have turned her back when Resident #79 had just finished dinner. Resident #79 got through the stairwell door. Staff G acknowledges at that time, she thought there was only a door by the dayroom. She was not aware of the back door. She was new and did not know. Honestly, she had not realized he had left or he was somewhere. She realized it when Staff H brought the resident in the unit and Staff H told Staff G that he got out. Staff G reported she was not sure how long he was outside, but it was not much longer after the meal. She did not hear an alarm going off. She let the DON know they could not hear the alarm. The alarm was far enough away and if the staff were in the dining room they could not hear the alarm. Staff G reported since the incident she thought maintenance made the alarm louder, a monitor was installed in the dining room, and they increased hallway checks. Staff reported she did not know if Staff I checked to see if a resident or someone left the unit. This was an isolated event. They got education about the elopement and the need to get to the alarm right away. In an interview 4/29/26 at 6:40 PM, Staff H, RN, reported the staffing level on the 2 PM to 10 PM included 1 nurse, 1 CMA, and 2 CNA's on the Memory Care unit. The staffing ratio was fine when their routine and things went well, but when things happen such as a resident fall or a change in condition, then staffing was not so fine. The facility had alarms on the front door to the main area and exit door in the Memory Care unit. The exit doors required a code whenever someone entered or exited the area. The doors would unlock after 15 seconds when the door was pushed. The door alarmed but after 15 seconds you can push the door open and go outside. Staff H reported Resident #79 used a walker and ambulated around the unit a lot. He was very intense, anxious and very wandery. He talked about people dying in a plane crash and that he had to get to the airport. Staff H reported on the day of the incident, she was coming in from the parking lot and Resident #79 was right in front of her. Staff H did not know how he got there. He had grippy socks on but did not have shoes on. She did not know what was going on. She asked what he was doing. Resident #79 was confused. Staff H told him to come with her, she would keep him safe. Staff H took him through the door by the employee entrance and then took him back to the unit. Staff H told Staff G where she found Resident #79 in the parking lot. Staff L and Staff I were in the dining room feeding residents. The staff told Staff H that Resident #79 had just been in the dining room eating. Staff H thought it had only been a short moment that Resident #79 was out of the unit. After that happened, they put a baby monitor in so staff could hear on the other side of the unit. Staff H explained she did not even realize anyone could get to the back parking from the back door fire escape. In an interview on 4/29/26 at 1:01 PM, Staff F, CMA, reported the Memory Care unit needed at least three CNA's in the Memory Care unit due to the types of residents and their needs. Several residents required two staff assistance for transfers. When two staff were in a room providing cares or doing a transfer, the CNA's cannot watch the rest of the residents in the unit or know what is going on in the unit. In an interview on 4/30/26 at 9:50 AM, the Assistant Maintenance Supervisor reported doors were checked weekly to ensure they functioned properly. He reported the unit door, the door to the courtyard, and the South back fire exit door had an alarm. The South (back) Exit door led to another door (unalarmed) and this led to the outside employee parking lot. The Assistant Environmental Director reported a monitor was installed by the South Exit door so staff could hear the alarm. Staff are supposed to check the alarm when the alarm went off. In an interview on 4/30/26 at 10:10 AM, the Administrator reported they received a report for the fire system when the fire alarm went off but not the door alarms. The Administrator was unable to verify when a door alarm went off or when the exit door was breached. In an email on 4/30/26 at 10:21 AM, the Administrator wrote she double checked the documentation. The resident was shown exiting the door at approximately 5:43 PM, the RN walked with him back to the building at 5:45 PM, and entered the building at 5:48 PM. The total time of the incident was 5 (continued on next page)

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 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)

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on. At 1:11 PM a Certified Nurses Aide (CNA) walks into the room to answer the call light and assist the resident.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview and policy review the facility failed to handle and serve food in a sanitary manner to prevent cross-contamination for 2 of 2 meals observed. The facility staff also failed to handle and transport contaminated linens in a manner to prevent contamination and the potential spread of infection for 1 of 4 units. The facility reported a census of 76 residents.Findings include: 1.During observation of dining on 4/28/26 starting at 8:39 AM, Staff D, certified nursing assistant (CNA) sat down at an assisted diners table with eight residents. Staff D offered a bite of food to one of the residents. Staff D placed her bare left hand over a croissant breakfast sandwich, took a knife, cut the sandwich in half and gave the sandwich to Resident # 64. Resident #64 held the sandwich in his hand and fed himself. Staff D then placed her bare hand over Resident #27's croissant sandwich, cut the sandwich in half and fed Resident #27. At 8:48 AM, Staff E, CNA, rubbed her fingers on her head then picked up a glass of chocolate milk and offered Resident #31 a drink. Staff E then picked up a glass of chocolate milk and offered the milk to Resident #33. During the meal service, Staff E rubbed her eye, then placed a fork full of food into Resident #33's mouth. The food stuck on the outside of the resident's lips. Staff E used her bare fingers, pulled the food out of Resident #33's mouth, then moved to the next resident at the table and gave the resident a bite of cereal. Staff E assisted three residents at the assisted diners table during this time. Staff E then picked up a croissant sandwich with her bare hand and placed the sandwich into the resident's mouth for the resident to take a bite. Staff D and Staff E did not sanitize their hands between residents during the meal service. In an interview on 4/30/26 at 10:55 AM, the Director of Nursing reported she expected staff not to touch food with their bare hands, and sanitize hands between each resident. A Food Preparation and Service policy reviewed 1/9/26 directed staff as follows; food shall be prepared and served in a manner that complies with safe food handling practices. Bare hand contact with food is prohibited. A fork, spoon or knife shall be used to serve food. 2. During an observation on 4/30/26 at 9:32 AM, Staff S, Housekeeping Supervisor and Staff T, Laundry Aide, transported a rolling rack of clean personal clothing through one of four hallways. The rolling rack had a single white sheet placed over the top of clothing, which covered the top half of the clean clothing, the bottom half remained uncovered and exposed during transport. Staff S and Staff T both observed removing the clean personal clothing from the rack, and held clothing close to the body, touching each staff's uniforms, as clothing was taken into the resident rooms. During an interview on 4/30/26 at 9:34 AM, Staff T confirmed that bottom half of clean personal clothing remained uncovered and exposed while passing clothing and denied using any other clean clothing racks or covers to transport the clean clothing through hallways. During an interview on 4/30/26 at 10:07 AM the Director of Nursing (DON)/Infection Preventionist, revealed an expectation that clean linen is fully covered when transported through the hallways and expected all staff to hold clean linen away from their bodies to prevent possible contamination or the risk to spread infection. Review of the facility policy titled, Handling of linen, revised on 4/12/24, directed staff as follows; that when clean linen is being passed on resident units, it should be covered.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, resident interview, staff interview, clinical record review, and facility policy review, the facility failed to ensure a lap belt device, that may restrain a resident's movement, was assessed for safe use upon initiation and periodically following implementation for 1 of 4 residents reviewed for assessment and intervention. The facility reported a census of 76 residents. Findings include:During an observation on 4/27/26 at 1:15 PM, Resident #4 sat in electric wheelchair as staff pushed the chair from the dining room into the common room on her hallway, a lap belt fixed above the back wheel on both sides of the chair appeared secured at Resident #4's waist. Review of the Minimum Data Set (MDS) assessment, dated 4/01/26, revealed a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated Resident #4 had moderate cognitive impairment. The list of diagnoses included Heart Failure, Peripheral Vascular Disease (PVD), diabetes mellitus, anxiety disorder, and depression. The MDS indicated that Resident #4 was dependent on staff assistance for all transfers, cares, and wheelchair mobility. The MDS revealed that Resident #4 did not use any restraints or alarms on bed, on chair, or outside of bed. Review of the Care Plan, revised 4/07/26, lacked identification of a lap belt utilized on Resident #4's electric wheelchair or interventions related to the device. Review of Resident #4's Electronic Health Records (EHR) lacked documentation of device assessment or indication for use by provider. During an interview on 4/30/26 at 9:40 AM, Resident #4 sat in wheelchair in her room with lap belt secured at her waist. When asked if Resident #4 could remove her lap belt, she denied ability to remove lap belt and said staff have to do it. During an interview on 4/30/26 at 9:36 AM, Staff C, Registered Nurse (RN) reported working at the facility for over 1 year and said that a lap belt was being used on Resident #4's electric wheelchair throughout that time. Staff C denied completing any assessments on Resident #4's lap belt and when queried if Resident #4 could remove the lap belt on her own, Staff C stated, I think so. During an interview on 4/30/26 at 1:37 PM, Staff R, Certified Nursing Assistant (CNA) reported working at the facility for over 1 year and said that a lap belt was being used on Resident #4's electric wheelchair throughout that time. Staff C reported that she would mostly remove the lap belt for Resident #4 because resident was usually too tired. During an interview on 4/30/26 at 10:57 AM, Director of Nursing (DON) reported inability to find an assessment or documented indication for use of Resident #4's lap belt. Review of the facility policy titled, Restraints, Physical, revised 10/14/22, revealed that facility would use restraints only under the following conditions: As a last resort measure after a trial period where less restrictive measures have been undertaken and proven unsuccessful. Restraints shall not be used for disciplinary purposes, for staff convenience, or to reduce the need for care of residents during periods of understaffing. With a physician order and only when necessary to prevent injury to the resident or others, based on a physical, functional, emotional, and medication assessment. With the consent of the resident or his/her representative. When the benefits of the restraint outweigh the risks. No restraints that require a tie will be used. Whenever restraints are used a call signal switch or similar device within reach or other appropriate method of communication shall be provided to the resident. The Section titled, Procedure directed the following, in part: Residents who would benefit from a device that matches the definition of a restraint will be thoroughly evaluated for the need for that device, the safe application and use of that device, and the life enhancement or safety it will provide for the resident.Nursing will complete the Device-Equipment Observation And Consent when a symptom exists for which the need to use a restraint has been identified and after alternative measures have proven unsuccessful. The Observation will be reviewed by the IDT for additional input as needed.No tie-type restraints will be used. Linen shall not be used as a restraint. If a restraint is deemed necessary, a physician's order that contains the following information will be obtained: Medical symptom for use of restraint; Type of restraint; Duration and circumstances under which the restraint is to be used, including intervals for (continued on next page)

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	release/monitoring.Device will be removed at meals or for certain activities as appropriate per assessment.Nursing will discuss the risks/benefits of physical restraints with resident or resident representative and document this in the progress notes.Nursing will update the plan of care with restraint order and interventions, initiate orders for scheduling of restraint interventions, and will update Nursing Assistant assignment sheet and/or Resident Profile. Nursing will obtain written consent for physical restraint from the resident or their resident representative. If nursing is unable to obtain written consent, verbal consent will be obtained while waiting for written consent.Nursing will assess restraint usage every shift and will record these assessments/checks in the electronic health record.Nursing will complete a Device-Equipment Observation quarterly for review by the IDT. Re-evaluation of the continued need for the restraint, symptom, duration, and a restraint reduction plan will be discussed by the IDT at that time with corresponding documentation by all disciplines.Residents with restraints are observed every 15 minutes and restraints are released every 2 hours and as needed for safety, comfort, exercise, and elimination needs for a minimum of 10 minutes and the activity shall be documented in the resident record.

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.

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 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.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, manufacturer's instructions for use, resident representative and staff interview, and policy review the facility staff failed to administer medications and follow the doctor's order for one of six residents reviewed for medication administration (Resident #31). Facility staff gave morphine (an opioid pain medication) instead of lorazepam (an antianxiety medication), administered insulin to the wrong resident, and failed to administer insulin according to manufacturers' instructions for use for 1 for 2 residents reviewed for insulin use (Resident #5) The facility reported a census of 76 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnoses of Alzheimer's Disease and anxiety disorder. The resident had impaired short-term and long-term memory and severely impaired decision-making skills. The MDS recorded the resident had no injections or insulin orders during the seven-day look-back period. The MDS did not indicate the resident had a diagnoses of diabetes.Resident #31's Care Plan initiated on 1/26/26 revealed a diagnoses list. The diagnoses list lacked a diagnosis of diabetes. The Care Plan revealed the resident had altered cognition related to dementia and pain, and took an antianxiety medication and pain medication. The Care Plan directed staff to administer medications per the doctor's order. A Physician Order Notification Request dated 2/4/26 revealed Resident #31 was given Lorazepam (anti-anxiety medication) 0.5 milligrams (mg) at noon instead of 0.25 mg of Oxycodone (medication used for moderate pain). On 3/23/26, Resident #31 got glargine (a long-acting) insulin 23 units by accident. The provider gave an order to check blood sugars every hour for 24 hours and as needed (PRN), and follow hypoglycemic (low blood sugar) protocol if needed. Review of the Event History revealed the following medication incidents: a. On 2/4/26 at 2:47 PM, resident was given 0.5 mg of Lorazepam instead of 0.25 mg of Oxycodone during the noon meal. At 2:53 PM, during the narcotic count with Staff M, Registered Nurse (RN), it was noted that Staff L, RN, signed out Resident #31's Oxycodone, but gave one of Resident #39's 0.5mg Lorazepam. That was the conclusion based on the narcotic book. b. On 3/23/26 at 9:09 AM, Resident #31 received Glargine insulin (lowers blood sugar for approximately 24 hours) 23 units but had no order for Glargine. Orders received to check Resident #31's blood sugar every hour for 24 hours to monitor for low blood sugar. c. On 4/19/26 at 2:30 PM, during a medication administration review it was noted that Resident #31 received Morphine (strong pain med) instead of scheduled Ativan (used to treat anxiety) for the noon dose. Staff F, Certified Medication Aide (CMA), reported she did not give Lorazepam from the refrigerator but gave Morphine from the cart for the AM and noon medication passes. Resident #31 had a documented allergy to the medication that was given. In a confidential interview on 4/28/26 at 1:00 PM, a family member reported the quality of care had declined since the staffing schedule got changed. A few weeks ago, a nurse (Staff B) gave the resident insulin but the resident was not diabetic. The resident had to get her finger poked to monitor the blood sugar for 24 hours after the insulin had been given. Another time, Staff M, RN, called her to report the resident had her head to the side and was drooling. When Staff M came on duty and during their medication count it was discovered that the resident got Morphine instead of Lorazepam for the AM and lunch dose. A CMA gave Morphine twice instead of Lorazepam.In an interview on 4/28/26 at 4:37 PM, Staff B, RN, reported he was not familiar with residents on the Memory Care unit. He had worked at the facility for awhile and had to cover for certain things on other units when a CMA worked on the other unit. Staff B reported there was a lot going on on the day he made the insulin medication error. A CMA worked in Memory Care and Staff B was told that insulin needed to be given. He was trying to side saddle on the medication cart with the CMA at the same time, and he tried to get what he needed out of the medication cart. It just did not work very well having the CMA in the cart at the same time. He made a medication error and he felt really bad about that. He had never made a medication error in 20 years. The resident was fine after the error happened. Staff B reported he was not use to sharing a (continued on next page)

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cart when he prepared medications. In an interview on 4/29/26 at 1:01 PM, Staff F, CMA, reported she was supposed to check the five rights before she administered medications. She checked the MAR and medication card for the right resident, right medication, right dose and right time. She then popped the medication out and administered the medication to the resident, then documented the medication on the MAR. Staff F reported one day she gave morphine instead of lorazepam. On that day, she did not think. She saw morphine in the cart and did not think about the other medication stored in the refrigerator so she gave Morphine instead of Lorazepam. The resident did not have any issues but Staff F was upset that she made the error. Staff F reported she received education after the incident. In an interview on 4/30/26 at 10:55 AM, the DON reported she expected staff to follow the policy whenever they administered medications. She expected staff to check the resident's picture on the computer and ensured they had the right resident and checked the 6 rights. The DON reported education was provided to staff involved on the insulin medication error, as well as with the Lorazepam/Morphine error. A Medication Management Policy reviewed 9/30/25 revealed medications will be administered to residents as prescribed by the physician. Staff will follow the six rights of medication administration including the right resident, right medication, right dose, right dosage form, right frequency and right route. Resident photos are taken upon admission for the electronic health record and used as a method of identification for medication and treatment purposes.2. The Minimum Data Set (MDS) dated [DATE] identified Resident #5 had a Brief Interview for Mental Status (BIMS) score of 10 indicating moderate cognitive impairment. The MDS documented the resident had a diagnosis of diabetes. The MDS documented that the resident received insulin 7 out of the last 7 days for the MDS history review.Observation on 4/29/2026 at 7:40 AM Staff B, Registered Nurse (RN) gather Resident #5's Insulin Glargine pen. Staff B turned the dosage selector on the pen to the 18 units then put the needle cap on prior to entering the room. The insulin pen was not primed prior nor clean the rubber seal prior to putting the needle cap on. Staff B washed his hands, applied gloves and used alcohol to wipe the area on the abdomen. Staff B gave the insulin in the abdomen and held it for 10 seconds. During an interview on 4/29/2026 at 7:45 AM Staff B, RN reported he did not clean nor prime the insulin pen prior to administering the insulin. Observation on 4/29/2026 at 7:43 AM noted no insulin instruction with the insulin pen in the cart for Resident #5. During an interview on 4/29/2026 at 3:20 PM Director of Nursing (DON) reported staff are to follow the manufacturer's guidelines for insulin pens. She reported the nursing staff is supposed to prime the insulin pens prior to giving. Review of the manufacturer's instructions for use for the Insulin Glargine pen provided by the Administrator documented to wipe the rubber seal prior to attaching the needle cap then to do the needle safety test to ensure the resident correct dosage of insulin. The needle safety test is to prime the pen by turning the dosage selector to 2 units then push the injection button and when insulin comes out it is ready. It can be primed up to 3 times to ensure insulin comes out. Then the pen is ready to select the dosage order to inject into the resident. The instructions documented to not turn the dose selector or press the injection button without a needle attached because it can cause damage to the pen. The facility policy for insulin pens revised 3/25/24 directs staff to clean the rubber seal with alcohol before attaching the needle cap. Once needle capped to dial 2 units of insulin on the dose selector, point the needle up and firmly press the plunger until a drop of insulin appears at the needle tip. Repeat this step if a droplet does not appear.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interviews, the facility failed to date opened insulin for 1 of 2 medication carts inspected. The facility reported a census of 76 residents. Findings include: 0bervation on [DATE] at 10:18 AM with Staff C, Registered Nurse (RN) present, revealed the medication cart on Tulip Court noted the following insulins open and not dated: a. Resident #60 Lantus with a pharmacy delivery date of [DATE]. (Lantus expires 28 days after being opened) b Resident #1 Basaglar with a pharmacy delivery date of [DATE]. c .Resident #20 Novolog and Lantus with a pharmacy delivery date of [DATE]. (Novolog expires 28 after being opened) During an interview on [DATE] at 10:23 AM Staff C, RN reported the insulin should be dated when opened. Staff C reported if it is not then she goes by the delivery date from the pharmacy. During an interview on [DATE] at 3:21 PM the Director of Nursing (DON) reported staff are to label the insulin pens when opened. The DON reported Staff C reported to her about the expired insulin in the cart. The facility policy for insulin pens revised [DATE] directs staff to document the date open or use by date on the pen.