

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46999</p> <p>This citation pertains to intake# MI001500378</p> <p>Based on observation, interview and record review, the facility failed to follow the court appointed resident representative decisions as the rights of the resident who was adjudged incompetent by the court in 1 (Resident #4) of 1 resident reviewed for abuse, resulting in Resident #4 (who functioned at the level of a 6 year old child) experiencing feelings of frustration, confusion, and anger after witnessing ongoing conflict between facility staff and her family members/representatives.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: moderate intellectual disabilities (observable developmental delays, which may be accompanied by physical impairments), cerebral palsy (congenital disorder of movement, muscle tone, or posture) and major depressive disorder (persistent sad mood that impacts daily living). Further review revealed Family Member (FM) TT and FM UU served as co-guardians for Resident #4.</p> <p>Review of the court document labeled Letter of Co-Guardianship of individual with Developmental Disability dated as amended on 2/12/25 (for financial language) revealed FM TT and FM UU were appointed as plenary guardian of Resident #4.</p> <p>According to the American Bar Association, Generally, if a court determines a person has a disability, they may appoint (1) a guardian of the person, if it has been properly shown that because of their disability they lack sufficient understanding or capacity to make or communicate responsible decisions concerning the care of themselves .A plenary guardianship is a guardianship in which the court gives the guardian the power to exercise all legal rights and duties for the ward, after the court finds the ward to be incapacitated. People often mistake the guardian of the person as referring only to the authority to make healthcare decisions. However, the scope of these duties is far more extensive. The guardian of the person may make medical decisions, oversee the residential placement of their ward (with court approval), ensure that the ward receives proper professional services .</p> <p>Review of a Speech Therapy Evaluation for Resident #4 with a reference date of 2/21/25 revealed Clinical Impressions .Pt (patient) is goal directed .Pt's thinking is concrete .problem solving abilities are impaired and pt has limited insight .pt has difficulty with understanding problems, hazards or precautions.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Comprehensive Level II Evaluation for Resident #4 with a reference date of 4/29/24 revealed Strengths and Resources: (Resident #4's) guardians appear to be strong advocates in ensuring she is receiving appropriate care and remains happy . (Resident #4) meets DSM (Diagnostic and Statistical Manual) criteria for Intellectual Disability .deficits in intellectual functions .adaptive functioning .onset of deficits was during developmental period.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #4 with a reference date of 1/3/25, revealed Section D of the MDS revealed Resident #4 expressed feeling down, depressed, or hopeless during 7-11 days of the 14-day assessment period.</p> <p>Review of an MDS assessment for Resident 34 with a reference date of 10/3/24 revealed Resident #4 expressed feeling down, depressed, or hopeless never or less than 1 day during the 14-day assessment period.</p> <p>Review of a Care Plan for Resident #4 with a reference date of 7/2/24, revealed a focus/goal/interventions of: Focus(es). I have an alteration in my MOOD state r/t (related to) depression. When staff explain boundaries or rules, I will frequently make accusations against staff .I frequently tell different stories to different people. Goal: I will communicate my feelings. Interventions: .Do not interview resident and sister in presence of each other .as they have a HX (history) of feeding off each other .involve resident in decisions related to care .</p> <p>Review of a Behavioral Care Provider Note for Resident #4 with a reference date of 9/5/24 revealed .Her (Resident #4) sister is her guardian .She denies depression or anxiety .(Resident #4) has presented with manipulative behaviors such as telling her sister one account and staff another, which causes friction between all parties .Interventions staff could implement .Do not involve (Resident #4) in discussions between her sister and staff as it upsets (Resident #4).</p> <p>Review of a Social Services Initial Assessment for Resident #4 with a reference date of 7/3/24 revealed The patient is capable of making her basic needs and preferences known. Her guardian is tasked with complex decision making regarding the patient's health and wellbeing .The patient has a very supportive and involved family .</p> <p>In an interview on 3/17/25 at 10:55am, FM TT' reported she had voiced several concerns to the facility about Resident #4 spending time with a facility staff member (Scheduler EE), receiving notes of affection from Scheduler EE, and being referred to by Scheduler EE as her goddaughter but the facility had not intervened. FM TT reported she felt the relationship was inappropriate and that she had concerns for Resident #4's psychosocial wellbeing. FM TT reported one thing she hoped to avoid for Resident #4 was overhearing the staff gossip that took place while staff members interacted with Scheduler EE. FM TT reported Resident #4 repeated the information she heard and when asked, Resident #4 reported she heard it while Scheduler EE was checking staff in. FM TT reported although Resident #4 often didn't understand everything, she always paid close attention to what other's said and could pick up on the emotion involved in statements. FM TT reported during one meeting, in which Resident #4 was present, Director of Nursing (DON) B accused her of sucking the life out of (Resident #4). FM TT reported she felt the comment was inappropriate and added to Resident #4's emotional distress.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/17/25 at 11:20am, FM TT reported she also told the facility she was not comfortable with Scheduler EE referring to herself as Resident #4's godmother or calling the resident her goddaughter. FM TT reported using those terms would be confusing to Resident #4 as they would imply the scheduler was a family member.</p> <p>Review of an email written by FM TT to DON B dated 12/23/24 revealed (Resident #4) is mentally disabled . She must not hang out in (Scheduler EE s) office.</p> <p>Review of an email written by FM TT to DON B dated 12/24/24 revealed .as far as (Scheduler EE), it all started out good but not letters to god daughter from god mother I think is going a little bit to (sic) far .</p> <p>Review of an email written by FM TT to DON B dated 2/10/25 revealed I am requesting (Resident #4) not be in (Scheduler EE s) office .I feel that is a completely inappropriate relationship between (facility name) staff and a (facility name) resident .As (Resident #4's) guardian all private interactions between (Scheduler EE) and (Resident #4) must cease immediately. This includes but not limited to (Resident #4) being in (Scheduler EE s) office alone and (Scheduler EE) passing notes to (Resident #4).</p> <p>During an observation on 3/17/25 at 3:21pm, Resident #4 sat next to Scheduler EE in the scheduler's office. No other staff were present.</p> <p>In an interview on 3/17/25 at 3:38pm, Nursing Home Administrator (NHA) A reported FM TT had made several complaints about Resident #4 spending time with Scheduler EE, receiving notes from staff members and Resident #4 being referred to as Scheduler EE s goddaughter. NHA A reported FM EE felt the situations were inappropriate. NHA A then reported she felt FM TT doesn't want anything that makes (Resident #4) happy. NHA A reported based on Resident #4 voiced that she wanted to be called goddaughter but then added her (Resident #4's) wishes would go back and forth. NHA A reported the facility did not comply with FM TT s directions related to Resident #4 spending time alone with Scheduler EE, receiving notes from staff, or being referred to as Scheduler EE s goddaughter. NHA A reported Resident #4 had been present for a meeting with FM TT and facility staff and had become really upset during conflicts.</p> <p>In an interview on 3/17/25 at 10:40am, Scheduler EE reported Resident #4 regularly spent time in her office, and Scheduler EE enjoyed talking with her. Scheduler EE stated (Resident #4) brings me joy. Scheduler EE reported she liked to help Resident #4 manage her stress by helping her express her thoughts in a journal. Scheduler EE reported she transcribed Resident #4's thoughts in the journal for her. Scheduler EE reported she felt Resident #4 functioned as a [AGE] year-old child, rather than a 6-year-old as was documented in her medical record. Scheduler EE reported Resident #4 called her Godmother and she referred to Resident #4 as Goddaughter. Scheduler EE reported the facility allowed her to continue writing notes to Resident #4, and that she gave Resident #4 a note on this date that read BEE HAVE.</p> <p>In an interview on 3/17/25 at 1:11pm, Ombudsman QQ reported she had met with Resident #4 on several occasions. Ombudsman QQ confirmed that Resident #4 was inconsistent with statements regarding her wishes but had voiced that she enjoyed seeing Scheduler EE.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/18/25 at 2:19pm, FM TT reported Resident #4's mood had declined in recent months, and she began demonstrating behaviors she had never had before including breaking her cell phone three times, bouts of anger, refusal to see family members.</p> <p>In an interview on 3/18/25 at 2:54pm, Regional Director of Operations (RDO) RR reported staff members should fill out a concern form anytime a resident or family member had a concern. RDO RR reported the expectation was that the NHA would work to resolve any concerns and that the NHA kept him informed when concerns arose. RDO RR reported he was not aware FM TT wanted the staff to stop writing notes to Resident #4 and he expected that the NHA would have ensured the staff stop writing notes to the resident immediately. RDO RR reported he was aware that the stress of the situation impacted Resident #4 negatively.</p> <p>In an interview on 3/19/25 at 9:18am, FM UU reported Resident #4 was very soft hearted and could be easily lead astray. FM UU reported in recent months Resident #4's temperament had changed, and she'd become irritable, broken 3 cell phones, and at times refused to see FM UU and FM TT. FM UU reported until recently, she and Resident #4 were always very close, and Resident #4 would talk to her about her stressors. FM UU stated (Resident #4) is a different person in the last few months. FM UU reported she was concerned Resident #4 had become stressed and confused by the statements she'd heard facility staff say during meetings with her family. FM UU reported during one meeting DON B said Resident #4's family member was sucking the life out of her by not allowing her to do certain things. FM UU reported Resident #4 did not have the capacity to understand the complicated situation related to her family's concerns. FM UU described the environment for Resident #4 as unhealthy because she could not understand it when facility staff told her she had certain rights that she did not understand.</p> <p>In an interview on 3/19/25 at 10:51am, Social Work Director (SW) P reported Resident #4's mood had declined in recent months, and she appeared exhausted and defeated. SW P reported during a meeting with several facility staff, Resident #4's family members and Resident #4, a staff member told her she had the right to be friends with whomever she liked. SW P reported when she was asked what her wishes were, Resident #4 burst out crying and said she did not know what she wanted. When queried regarding non-direct care staff taking measures to attempt to assist a resident with their stress level, SW P reported it was not appropriate for those staff members to do so.</p> <p>In an interview on 3/19/25 at 12:02pm Medical Director (MD) SS reported Resident #4 did not have the capacity to consent to a relationship because she could not distinguish between a healthy versus a dysfunctional relationship. MD SS confirmed Resident #4 functioned as a 6-year-old child and as a result, he would expect the facility to honor the wishes of her guardians, including taking steps to ensure Resident #4 did not interact with Scheduler EE.</p> <p>In a second interview on 3/19/25 at 12:27pm, Scheduler EE reported Resident #4 displayed extreme mood swings in recent months and voiced she was stressed about the conflicts between the family and the staff. Scheduler EE reported she was aware FM TT did not want Resident #4 to receive notes from staff or spend time with her, but she felt Resident #4 enjoyed those things, so she wanted to continue those activities. Scheduler EE stated I feel it's inappropriate, regarding FM TT s wishes for Resident #4. Scheduler EE reported the facility developed a daily schedule for Resident #4 to spend time in her office doing tasks with her and required that the door be kept open. When further queried about how Resident #4 began completing tasks for her, Scheduler EE confirmed no member's of the Interdisciplinary Team had initiated that as a part of her plan of care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/19/25 at 12:56pm, DON B reported she was aware that Resident #4 continued to receive notes from and spend time with Scheduler EE almost daily. DON B reported the facility allowed these activities to continue despite the wishes of Resident #4's guardian/family member because DON B felt it was within the resident's rights. DON B then stated, If it makes (Resident #4) happy, then FM TT is going to squelch it. DON B then stated, I'm not a psychiatrist, but I think (FM TT) has (name of psychiatric condition omitted) and I think she needs professional help. DON B confirmed that FM TT clearly expressed she did not want Resident #4 to spend time with Scheduler EE, did not want Resident #4 to be referred to as the goddaughter of Scheduler EE, and did not want staff to write notes to the resident. DON B confirmed no steps had been taken to follow these requests. When further queried, DON B confirmed the facility had not pursued any options for meeting Resident #4's needs while also complying with FM TT's wishes. DON B confirmed that Resident #4 cannot consistently make decisions for herself, and the facility should follow the wishes of the guardian. DON B confirmed FM TT did not want Resident #4 to take part in meetings regarding her care, that a behavioral health provider had recommended the resident should not be included, but DON B had been present for more than 1 meeting of this type in which Resident #4 was present. When further queried, DON B reported the facility felt Resident #4 had a right to be present for meetings regarding her care. DON B confirmed the meetings involving Resident #4's family and facility staff were intense at times and that Resident #4 had become emotionally upset during the meetings. When queried regarding DON B making a comment that her family member was sucking the life out of her, DON B stated I don't recall those words, but I did say she was draining the fun out of everything for (Resident #4).</p> <p>Using the reasonable person concept, though Resident #4 had decreased ability to verbally express her emotional distress due to her developmental barriers, she clearly experienced frustration, mental anguish and confusion from the ongoing conflict between the facility and the resident's family members, as well as the comments made in her presence. This mental anguish has the potential to continue well past the date of the incidents based on the reasonable person concept.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47955</p> <p>This citation pertains to Intake #MI00149109</p> <p>Based on interview and record review the facility failed to maintain professional standards of nursing practice related to medication administration for 2 (Resident #2 and Resident #9) of 11 residents reviewed or professional standards of nursing practice resulting in both Resident #2 and Resident #9 being administered another resident's medications.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Review of Medication Error Report for Resident #2, dated 12/8/24 at 19:58 pm, (7:58 pm) completed by Registered Nurse (RN) II revealed . Resident administered roommate's (Resident #5) medications .</p> <p>In a telephone interview on 3/17/25 at 3:45 pm, RN II reported that on 12/8/24, Licensed Practical Nurse (LPN) T came from another hall to help her pass medications. RN II reported she was pulling medications (preparing them from the medication cart per the orders in the EMAR (electronic medication administration record) and giving the prepared medications to LPN T who was then administering the medication to the residents. RN II reported that she prepared all of Resident #5's evening medications, handed the medication cup to LPN T who then administered Resident #5's medications to Resident #2. RN II reported that the documentation in Resident #2 and Resident #5's EMAR were her initials indicating that she had administered Resident #2 and Resident #5's medications to them on 12/8/24, but it was LPN T who was administering medications to residents. RN II reported that the nurse that prepares the medications should be the nurse who administers and documents the medications according to the 5 rights of medication administration. RN II reported passing medications with another nurse has not happened since.</p> <p>In an interview on 3/18/25 at 10:15 am, LPN T reported on 12/8/24 she was assisting RN II to administer medications and she administered them to the wrong resident. LPN T reported RN II prepped Resident #5's medications, gave them to her and she gave Resident #5's medications to Resident #2. When queried about medication administration practices, LPN T reported the nurse who pulls the medication should administer them and the nurses need to use the 5 rights, such as right resident, right medication. LPN T stated I will never help anyone pass meds again.</p> <p>In an interview on 3/18/25 at 11:05 am, DON B reported her understanding of the medication error was that LPN T went to help RN II and they were dividing and conquering to pass the medications. LPN T was given the cup of medications after RN II pulled the medications, and LPN T when into the room. DON B reported that the nurse who pulls the medications should be the nurse who administers the medications. DON B reported she expected the nurses to use the rights of medication administration. DON B reported that she spoke to both LPN T and RN II and assigned education to only LPN T for a one-to-one education on the topic of medication administration.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN T documented one-to-one education dated 12/10/24 revealed education included regarding medication errors: nurse must verify meds with 2 identifiers, ensure correct dose, frequency, time, route, patient, drug and documentation, take your time. The one-to-one education was signed by LPN T. Also included in LPN T one-to-one education was a form that revealed 10 rights of drug administration right drug, right patient, right dose, right route, right time and frequency, documentation, history and physical, drug approach and right to refuse, drug-drug interaction and evaluation, education and information</p> <p>There was no one-to-one education provided for RN II by the time of exit.</p> <p>Resident #9</p> <p>Review of Medication Error Report for Resident #9 dated 1/10/2025 at 10:31 am, completed by RN S revealed after giving am medication realized that I had given another resident's medication to (Name Omitted) Resident #9 .</p> <p>In a telephone interview on 3/18/25 at 1:01 pm, RN S reported she mixed up the identity of Resident #9 with Resident #10. RN S reported that Resident #9 and Resident #10 both use reclining wheelchairs, were both in the dining room, and they were in close proximity to each other when she administered the wrong medications to Resident #9. RN S reported she knows who Resident #9 and Resident #10 are. RN S reported she received one-to-one education, and it included the 5 rights of medication administration. RN S reported that right resident was one of the rights to medication administration.</p> <p>In an interview on 3/18/25 at 12:44 pm, DON B reported when the medication error occurred for Resident #9, RN S was distracted by behaviors and other residents while she was in the middle of her medication pass. DON B reported that RN S had worked with Resident #9 for a long time and knew the residents in that part of the building well. DON B reported her one-to-one education for RN S was more detailed than the education for the medication error that occurred in December (for Resident #2's medication error), because there were different circumstances.</p> <p>Review of one-to-one education for RN S dated 1/10/2025 revealed .ensure the five rights of medication administration are adhered to. Every time you administer a dose, it's important to keep the five rights of medication in mind. This is one of the easiest ways to prevent medication errors in nursing and should be reviewed upon each administration of medication. These rights' include: the right resident .the right drug .the right dose .the right route .the right time . RN S is noted to have signed the one-to-one education.</p> <p>In an interview on 3/19/25 at 1:40 pm, Life Enrichment Aide (LEA) V reported that Resident #9 did not speak, and she did not believe she would be able to verbalize her own name.</p> <p>In an interview on 3/19/25 at 1:45 pm, Clinical Care Coordinator/Licensed Practical Nurse (CCC/LPN) DD reported he did not believe Resident #9 would verbalize her own name. CCC/LPN DD reported to identify a resident for medication administration the nurse should look at the picture in the medical record, and the name on the door of their room. When queried, regarding how to identify a resident who was unable to answer or verbalize or confirm their own name, CCC/LPN DD stated that's a good question, let's go ask the nurse, I would like to know how to also.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/19/25 at 1:50 pm, LPN C reported to identify a resident for medication administration she would look at the picture in the medical record and use the name on the door and administer medication per the 5 rights.</p> <p>In an interview on 3/19/25 at 1:55 pm, RN I reported to identify a resident for medication administration she would use the name on the door and then ask another staff if she did not know the resident.</p> <p>In an interview on 3/19/25 at 2 pm, DON B reported she would verify the name and picture in the medical record, and make sure the name on the medications matched. DON B reported she would use the resident name on the room door, and make sure the face in the bed matches. DON 'B stated the nurses who work the long-term halls know who the residents are. DON B reported that her expectations were that the nurses' verified the identity of the residents before they administered medications and administered medications they had prepared.</p> <p>Review of facility policy Section IID: Specific Medication Administration Procedures with a revision date of January 2015, revealed . 6. The person who prepares the dose for administration is the person who administers the dose. 7. Residents are identified before medication is administered. Methods of identification include: .b. checking photograph attached to medical record . c. if necessary, verifying resident identification with other facility personnel .C. Documentation .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given .</p> <p>Lippincott's online Nursing Center 2015 reflected 8 rights of medication administration:</p> <ol style="list-style-type: none"> <li>1. Right patient 5. Right time</li> <li>2. Right medication 6. Right documentation</li> <li>3. Right dose 7. Right reason</li> <li>4. Right route 8. Right response</li> </ol>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47955</p> <p>This citation pertains to Intake #MI00149109</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents were free from significant medication errors in 2 (Resident #2 and Resident #9) of 2 residents reviewed for significant medication errors resulting in Resident #2 experiencing an altered level of consciousness, lethargy (decreased alertness and response), decreased oral intake, decreased blood pressure, and the need for supplemental oxygen.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Review of an Admission Record revealed Resident #2 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Type 2 diabetes (a long-term condition where the body does not use insulin properly and there is too much sugar circulating in the blood), hypertension (high blood pressure), and dementia.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #2, with a reference date of 1/2/2025 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #2 was cognitively intact. (BIMS score 13-15 indicates cognitively intact).</p> <p>Review of Medication Error Report for Resident #2, dated 12/8/24 at 19:58 pm, (7:58 pm) completed by Registered Nurse (RN) II revealed . Resident administered roommate's (Resident #5) medications . (including) buspirone HCl tablet 10mg x 2, (anti-depressant), clonazepam oral tablet 0.25 mg (anti-psychotic), apixaban oral tablet 5 mg (anti-coagulant/blood thinner), Senna oral tablet 8.6 mg (laxative), senna- plus 8.6-50 mg (laxative/stool softener), Tropism Chloride oral tablet 20 mg (treats over active bladder and urinary incontinent), Atorvastatin 20 mg (cholesterol medication), insulin 8 units injection subcutaneous (diabetes/high blood sugar), Latuda oral tablet 40 mg (depression associated with bipolar disorder), Melatonin 3 mg x 2 (two tablets) (sleep aid), Morphine Sulfate 15 mg (narcotic pain medication) .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 3/13/25 at 12:10 pm, Family Member (FM) MM reported he was notified via telephone on 12/8/24 at about 7:45 pm by Licensed Practical Nurse (LPN) T, a nurse who was working at the facility that night and was told that she had administered Resident #2's roommates'(Resident #5) medications to Resident #2. FM MM reported he inquired as to what medication was given to his mother, Resident #2 and LPN T denied answering that question. FM MM reported the facility had never communicated to him what medications Resident #2 received that day. FM MM reported for 3 days he attempted to reach staff, including Nursing Home Administrator (NHA) A and Director of Nursing (DON) B, at the facility to get an update on Resident #2's condition and had to leave messages, or was rushed off the phone by staff. FM MM reported he felt as if he was being brushed off, ignored, and that Resident #2's condition was not a concern for the staff. FM MM' reported he was frustrated by the lack of communication from the facility, as he resides out of state and was not able to visit Resident #2. FM MM reported he had to reach out to Resident #2's hospice provider to assess Resident #2 and to receive an update on her condition via a telephone call after Resident #2 was assessed, where he was assured by a hospice nurse that Resident #2 was doing ok and was coming out of it (the adverse effects of the medication error).</p> <p>During an interview on 3/13/25 at 1:05 pm, Resident #2 greeted this surveyor and stated her name. When queried, Resident #2 reported she recalled a time a while back when she was out of it but she did not recall any further details.</p> <p>In a telephone interview on 3/13/25 at 2:48 pm, FM NN reported she visited her mother, Resident #2 on Tuesday, December 10, 2024, two days after the medication error occurred and Resident #2 was completely out of it, hallucinating, hard to wake up, unable to stay awake. FM NN stated my mother did not know who I was. FM NN reported that Resident #2 knew all her children on sight and was usually very talkative. FM NN reported on that day Resident #2 was wearing oxygen and that Resident #2 had not needed oxygen in several months. FM NN reported she felt completely helpless when she saw Resident #2 in that condition and was not sure Resident #2 would come out of it.</p> <p>In a telephone interview on 3/17/25 at 9:34 am, FM OO reported he visited his mother, Resident #2 the day after the medication error occurred and Resident #2 was in never never land. FM OO reported Resident #2 appeared to be spaced out and could not comprehend who he was or what he was saying. FM OO reported he spoke to Clinical Care Coordinator/Licensed Practical Nurse (CCC/LPN) DD and was assured that the medications Resident #2 received were not that potent and that Resident #2 would come out of it in about 8 hours. FM OO reported it was two and a half weeks before Resident #2 was completely coherent during visits again.</p> <p>In an interview on 3/17/25 at 1:30 pm, LPN BB reported that Resident #2 did have a medication error a few months back. LPN BB reported two nurses were working together to pass the medications to the residents on the hall and Resident #2 got Resident #5's evening medications. LPN BB reported she had not received any education regarding medication administration after that incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on 3/17/25 at 3:45 pm, RN II reported she had stayed over to help out into the evening shift to cover the hall where Residents #2 and #5 resided as there was not a staff member for the assignment. RN II reported that she was behind with the medication pass, and that LPN T came from another hall to help her. RN II reported she was pulling medications (preparing them from the medication cart per the orders in the EMAR (electronic medication administration record)) and giving the prepared medications to LPN T who was then administering the medication to the residents. RN II reported that she prepared all of Resident #5's evening medications, handed the medication cup to LPN T who then administered Resident #5's medications to Resident #2. RN II reported Resident #5 takes several medications in the evening, and that she had prepared all of Resident #5's medication that were due at that time and gave them to LPN T to administer. RN II reported they were most concerned with Resident #2 reaction to receiving insulin and morphine sulfate.</p> <p>Review of Resident #2's medical record revealed no noted documentation regarding her being administered the wrong medications on 12/8/24.</p> <p>Review of Nurses Notes for Resident #2 revealed 12/9/24 17:37 (5:37 pm) Resident was tired today-she would respond to questions and would wake up upon asking questions but the minute we left the room she went back to sleep. Denied breakfast and lunch . 12/9/24 23:25 (11:25 pm) Resident lethargic this shift. Resting in bed sleeping with even respirations noted. No facial grimacing or groaning, resident does not seem to be in any pain. Vitals assessed with low BP (blood pressure) of 96/60 but resident remains stable. Remains on 2L O2 (2 liters of oxygen) via NC (nasal cannula) with sat (oxygen saturation) of 97 (90-100 indicates adequate oxygenation). Resident was able to take all scheduled medications PO (by mouth) with meds crushed in pudding . 12/10/24 4:25 am Resident remains lethargic, however every time resident awakes for vital checks she gradually seems more alert VSS (vital signs stable) and documented throughout shift.</p> <p>Review of Resident #2's medical record revealed no noted documentation of a provider visit following the medication error that occurred on 12/8/24.</p> <p>Review of Facility Visit and Collaboration Form for Resident #2 dated for 12/10/24 at 19:40 (7:40 pm) revealed .PRN (as needed) visit per son's request . indicating Resident did not look good today . her RR (respiratory rate) was 17 bpm (beats per minute), slightly irregular .oxygen at 2L via nasal cannula .she focused on this RN throughout visit, but did not say any words .offered her a some water with a cup and straw . did not appear to know how to use the straw .spoke with Competency-Evaluated Nursing Assistant (CENA) AA and CENA HH who reported that (Resident #2) has been more tired and out of it these past few days .</p> <p>In an interview on 3/18/25 at 11:05 am, DON B reported her understanding of the medication error was that LPN T went to help RN II pass medications, it's a long hall (indicating there are many residents on that hallway) and I don't remember what happened, and they were dividing and conquering to pass the medications, LPN T was never assigned to work that hall, and LPN T got the cup of medications after RN II pulled the medications, and LPN T when into the room. Resident #2 was on one side, and Resident #5 was on the other side and LPN T gave Resident #5's medications to Resident #2. DON B stated there didn't appear to be any negative outcome. DON B reported that she spoke to both LPN T and RN II and assigned education to only LPN T for a one-to-one education on the topic of medication administration. When queried, DON B reported that all nursing staff were not educated on medication administration at that time, but it was a topic of the all-staff meeting on 1/15/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN T documented one-to-one education dated 12/10/24 revealed education included regarding medication errors: nurse must verify meds with 2 identifiers, ensure correct dose, frequency, time, route, patient, drug and documentation, take your time. The one-to-one education was signed by LPN T. Also included in LPN T one-to-one education was a form that revealed 10 rights of drug administration right drug, right patient, right dose, right route, right time and frequency, documentation, history and physical, drug approach and right to refuse, drug-drug interaction and evaluation, education and information</p> <p>There was no one-to-one education provided for RN II by the time of exit.</p> <p>Resident #9</p> <p>Review of an Admission Record revealed Resident #9 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: alzheimer's disease and dementia.</p> <p>Review of Medication Error Report for Resident #9 dated 1/10/2025 at 10:31 am, completed by RN S revealed after giving am medication realized that I had given another resident's medication to (Resident #9). (Resident #9) received losartan 25 mg (blood pressure medication), magnesium 400 mg (vitamin), metformin 1000 mg (diabetes medication), pantoprazole DR 40 mg (stomach acid reducer), Senna-Docusate 8.6-50 mg (laxative and stool softener) two tabs .</p> <p>Review of Active Discharge Planning Note for Resident #9 dated 1/10/25 at 10:51 am revealed (Resident #9) received Losartan 25 mg, Magnesium 400 mg, Metformin 1000mg, Pantoprazole DR 40mg, Senna-Docusate 8.6-50 mg 2 tabs this am. Doctor informed, ordered to recheck VS (vital signs) in 4 hours. Will continue to monitor.</p> <p>No other documentation noted in Resident #9's medical record regarding Resident #9 receiving wrong medications on 1/10/25 or continued monitoring.</p> <p>In an interview on 3/18/25 at 12:44 pm, DON B reported when the medication error occurred for Resident #9, RN S was distracted by behaviors and other residents while she was in the middle of her medication pass and RN S informed DON B immediately after it happened. DON B reported her one-to-one education for RN S was more detailed than the education for the medication error that occurred in December (for Resident #2's medication error), because there were different circumstances. DON B reported that all staff were educated on 1/15/25 regarding medication errors during an all-staff meeting.</p> <p>In a telephone interview on 3/18/25 at 1:01 pm RN S reported she mixed up the identity of Resident #9 with Resident #10. RN S stated there are always things going on and there is a resident who is after everyone else's food, there are a lot of behaviors, and the television can be too loud, all those things can distract from medication administration. RN S reported that Resident #9 and Resident #10 both use reclining wheelchairs, were both in the dining room, and they were in close proximity to each other when she administered the wrong medications to Resident #9. RN S reported that she received one-to-one education regarding the medication error.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/19/25 at 9:45 am, DON B provided a typed word document that revealed Timeline for medication errors .12/8/24 .Resident #2 administered incorrect medication .root cause: did not verify resident identity .12/10/24 LPN T one-to-one education .1/10/25 .Resident #9 administered incorrect medication root cause: did not verify resident identity .1/15/25 nurses educated at monthly staff meeting . DON B confirmed that she had just created this documented timeline for the multiple medication errors that had occurred.</p> <p>In an interview on 3/19/25 at 2 pm, DON B reported that her expectations were that the nurses' verified the identity of the residents before they administered medications.</p> <p>Review of facility policy Section IID: Specific Medication Administration Procedures with a revision date of January 2015, revealed . 6. The person who prepares the dose for administration is the person who administers the dose. 7. Residents are identified before medication is administered. Methods of identification include: .b. checking photograph attached to medical record . c. if necessary, verifying resident identification with other facility personnel .C. Documentation .The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>47955</p> <p>Based on interview and record review the facility failed to maintain Quality Assurance and Performance Improvement Program (QAPI) that developed and implemented effective corrective actions and conduct meaningful surveillance to prevent adverse effects from medication errors in 2 of 2 residents (Resident #2 and Resident #9) reviewed for QAPI, resulting in the potential for serious adverse outcomes for all residents who receive medications from facility staff.</p> <p>Findings include:</p> <p>Review of Medication Error Report for Resident #2, dated 12/8/24 at 19:58 pm, (7:58 pm) completed by Registered Nurse (RN) II revealed . Resident administered roommate's (Resident #5) medications . (including) buspirone HCl tablet 10mg x 2, (anti-depressant), clonazepam oral tablet 0.25 mg (anti-psychotic), apixaban oral tablet 5 mg (anti-coagulant/blood thinner), Senna oral tablet 8.6 mg (laxative), senna- plus 8.6-50 mg (laxative/stool softener), Tropicism Chloride oral tablet 20 mg (treats over active bladder and urinary incontinent), Atorvastatin 20 mg (cholesterol medication), insulin 8 units injection subcutaneous (diabetes/high blood sugar), Latuda oral tablet 40 mg (depression associated with bipolar disorder), Melatonin 3 mg x 2 (two tablets) (sleep aid), Morphine Sulfate 15 mg (narcotic pain medication) .</p> <p>Review of Medication Error Report for Resident #9 dated 1/10/2025 at 10:31 am, completed by RN S revealed after giving am medication realized that I had given another resident's medication to (Resident #9). (Resident #9) received losartan 25 mg (blood pressure medication), magnesium 400 mg (vitamin), metformin 1000 mg (diabetes medication), pantoprazole DR 40 mg (stomach acid reducer), Senna-Docusate 8.6-50 mg (laxative and stool softener) two tabs .</p> <p>Review of the facility QAPI records revealed no documentation that the facility identified deficient practice related to medication errors, no process for analysis of the cause of medication errors, no plan for to correct the deficient practice, and no indication the facility would monitor, evaluate, or audit the correction.</p> <p>In an interview on 3/18/25 at 11:33 am, Director of Nursing (DON) B reported medication errors are a general topic for all QAPI meetings. DON B reported the medication errors that occurred in December and January were mentioned in the monthly QAPI meetings. When queried, DON B reported that nothing further was done to analyze the cause of medication errors.</p> <p>In an interview on 3/19/24 at 9:04 am, DON B, Nursing Home Administrator NHA A and Regional Clinical Nurse (RCN) PP were present in DON B office and NHA A reported that the mention of medication errors occurred in both January and February QAPI meetings, but there was no analysis into why it occurred or how to prevent medication errors from occurring in the future. NHA A reported all nursing staff was educated regarding medication errors at the all-staff meeting on January 15, 2025, and that there had not been an all-staff meeting in December.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 3/19/25 at 9:45 am, DON B provided a typed word document that revealed Timeline for medication errors .12/8/24 .administered incorrect medication .root cause: did not verify resident identity . 1/10/25 .administered incorrect medication root cause: did not verify resident identity . DON B confirmed that she had just created this documented timeline for the multiple medication errors that had occurred.</p> <p>The facility was unable to provide any root cause analysis created by the QAPI team by the time of exit.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955</b></p> <p>Based on observation, interview, and record review the facility failed to ensure staff implemented infection control measures by: 1). Implementing enhanced barrier precautions (EBP) for a resident with a urinary catheter in 1 (Resident #2) of 1 resident reviewed for EBP implementation and 2.) provide adequate storage of a CPAP (continuous positive airway pressure) mask for 2 (Resident #5 and Resident #6) of 2 resident reviewed for CPAP mask use, resulting in the potential for the introduction of infection, cross contamination, and disease transmission.</p> <p>Findings include:</p> <p>Resident #2</p> <p>Review of an Admission Record revealed Resident #2 was a female who was originally admitted to the facility on [DATE].</p> <p>On 3/13/25 at 1:05 pm, a urinary drainage bag was noted on Resident #2 bed frame, indicating the use of a urinary catheter. No signage was noted outside of the room indicating the use of enhanced barrier precautions.</p> <p>Review of Order Summary for Resident #2 on 3/13/25 revealed Foley catheter 16 fr (French) for buttock wound, started on 2/14/25 . there was no noted order for EBP.</p> <p>Review of Care Plan for Resident #2 on 3/13/25 revealed no noted care plan for EBP.</p> <p>On 3/17/25 at 10:27 am, Resident #2 was observed being transferred via a mechanical lift from bed into a shower chair by Competency- Evaluated Nurses Assistant (CENA) M' and Hospice Aide (HA) JJ. Neither staff member was wearing a gown.</p> <p>On 3/17/25 at 10:56 am, HA JJ was observed in Resident #2's room, removing the sheet from the bed and was not wearing a gown or gloves.</p> <p>In an interview on 3/18/25 at 9:50 am, CENA N and CENA Q reported that EBP was implemented for any resident who had a catheter. CENA N reported that staff should wear a gown and gloves during care when they will touch the resident, such as showers, incontinent care, transferring, and wound care.</p> <p>In an interview on 3/18/25 at 10:44 am, Infection Preventionist/Registered Nurse (IP/RN) J reported a resident who had a foley catheter should be in EBP.</p> <p>In an interview on 3/18/24 at 10:59 am, IP/RN J was queried regarding when Resident #2 was placed into EBP and IP/RN J stated about a half an hour ago. IP/RN J reported she had missed when Resident #2's foley catheter was ordered and did not update Resident #2 EBP status. IP/RN J reported she had entered the order for EBP and had updated Resident #2 care plan as well.</p> <p>Resident #5</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/19/2025
NAME OF PROVIDER OR SUPPLIER  Valley View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Four Mile NW Grand Rapids, MI 49544	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Admission Record revealed Resident #5 was a female who was originally admitted to the facility on [DATE].</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 12/26/2024 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #5 was moderately cognitively impaired. (BIMS score 8-12 indicates moderate cognitive impairment).</p> <p>On 3/13/25 at 1:09 pm, Resident #5's CPAP mask was noted to be laying on the floor between the bed and the wall.</p> <p>On 3/17/25 at 10:28 am, Resident #5's CPAP mask was noted to be laying on the over the bed table with no barrier and the mask appeared to be smudged with oil.</p> <p>In an interview on 3/17/25 at 2:55 pm, Resident #5 reported she uses her CPAP nightly, and the staff assist her to put it on. Resident #5 reported the staff takes care of her CPAP mask when she takes it off in the morning.</p> <p>Resident #6</p> <p>Review of an Admission Record revealed Resident #6 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included obstructive sleep apnea.</p> <p>On 3/13/25 at 12:50 pm, Resident #6's CPAP mask was noted to be laying uncovered on the top of the dresser with no barrier under it.</p> <p>In an interview on 3/13/25 at 12:55 pm, Resident #6 reported his CPAP machine was brand new and he had never used it and he didn't know anything about how it worked.</p> <p>Review of Order Summary for Resident #6 revealed .CPAP on at night, off in the am with a start date of 3/10/25.</p> <p>On 3/17/25 at 9:05 am, Resident #6's CPAP mask was noted to be lying on top of the dresser, with a washcloth and towel covering it. Resident was noted to be wearing a gown and sleeping in bed.</p> <p>In an interview on 3/17/25 at 3:30 pm, CENA X and CENA FF reported they did nothing with resident CPAP masks.</p> <p>In an interview on 3/17/25 at 3:12 pm, LPN K reported that CPAP masks should be stored in a bag or in a basin when not in use.</p> <p>In an interview on 3/18/25 at 11:15 am, Director of Nursing (DON) B reported her expectations were that CPAP masks were stored with a barrier of some kind when not in use.</p>