

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  09/24/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake #2614156. Based on interview and record review the facility failed to adequately supervise, ensure safety and prevent an elopement of 1 (Resident #100) of 3 residents who were assessed to be at risk for elopement, resulting in an Immediate Jeopardy when Resident #100 left the premises on 8/30/25, alone, unbeknownst to staff and was returned on 8/31/25 after being missing for approximately 17 hours. The deficient practice placed all 17 residents at risk for elopement at risk for serious harm, serious injury, and/or death. Findings include: The Immediate Jeopardy began on 8/30/25 and was identified on 9/22/25 due to the facility's failure to adequately supervise, ensure safety, and prevent an elopement resulting in Resident #100 eloping from the building and was subsequently missing for approximately 17 hours. On 9/22/25 at 2:55 PM, the Nursing Home Administrator was verbally notified and received written notification of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 8/31/25, and the deficient practice corrected on 9/16/25 prior to the start of the survey and was therefore past noncompliance. Review of Incident Summary revealed On 8/30/25, around lunch time the facility staff were unable to locate Resident #100. A code 7 was paged overhead to initiate missing person drill. He was last seen in the facility with a navy blue shirt, blue jeans, and blue tennis shoes. The Administrator, Director of Nursing, Regional Director of Operations, guardian, and police were notified of the missing person. The police arrived at the facility to help initiate a missing person search. They combed through neighborhoods and added the missing person to local news stations. All areas of business, wooded areas, apartments were searched by staff and local police. Flyers were handed out to local businesses and the bus lines. The police called the local hotels. Facility called a local homeless shelter. The resident's room was searched. The police started using a drone to search &amp; posted the missing person alert on their Facebook page. The sign out book was checked. The police were able to make visits to previous addresses with no success. At 4:40 am the resident entered a local hotel and told the front desk he just arrived. He did have brush &amp; burs on him and they thought that was odd and notified the local police. The resident was located by the local police department and taken to the hospital for evaluation. The patient returned to the facility around 5:45 am. The patient was assessed and no significant injuries were noted. The patient was immediately placed on 1:1. A full head-to-toe assessment was conducted on-site who found no acute injuries or medical concerns. In an interview on 9/22/25 at 12:02 PM, Maintenance Director (MD) SS reported all exit doors to the outside have an alarm system and/or the wander guard system; most doors have both systems. The doors at the end of the 600 hall had a coded alarm, but no wander guard system. MD SS reported the wander guard system was installed on the 600 hall doors and the entire wander guard system was upgraded in the facility on 9/3/25, after Resident #100 eloped. MD SS reported he reviewed the report for the wander guard system from 8/30/25 and the report indicated that no wander guard alarm had occurred when Resident #100 was suspected of exiting the building. In an interview on 9/22/25 at 11:18 AM, Housekeeper (H) AA reported Resident #100 was always trying find a way out of the building. H AA reported on 8/30/25 Resident #100 asked her how to get to the motel to get his wife. H AA reported she notified Licensed Practical Nurse (LPN) HH that Resident #100 was exit seeking. Review of Social Service Note for Resident #100 dated 8/30/2025 at 8:03 AM, revealed .patient asked if he could be let out of the facility so that he could go back to the hotel that he was at last night . Patient stated that he has been trying to go and pick up his wife. Review of Social Service Note for Resident #100 dated 8/30/2025 at 8:47 AM, revealed .Patient observed going out of the courtyard doors.went (sic) to make sure the patient knew how to get back inside when he was ready. The patient cut across the courtyard and re-entered the facility at the 200 hall entrance (from the courtyard). Approx 10 mins (minutes) later patient was on the 500 hall asking for help to open the doors. In an interview on 9/22/25 at 1:31 PM, Social Work Director (SWD) S reported Resident #100 was admitted to the facility for sub-acute rehab (rehabilitation outside of an acute care hospital or following a hospitalization) and shortly after he admitted he was at the doors, in other resident's rooms, very confused, and it was obvious he was not appropriate for the setting. SWD S reported on 8/30/25 Resident #100 asked her during breakfast for directions to the hotel so he could get his wife. SWD S reported on 8/30/25 at about 8:45 AM, she observed Resident #100 go out the door into the courtyard and the door alarm sounded. SWD S reported the doors to the courtyard were not locked and the alarm would sound unless the code was entered before the door was opened. SWD S reported on 8/30/25 after breakfast she heard Resident #100 make a few laps around the</p>		