STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026
NAME OF PROVIDER OR SUPPLIER Valley Vista Care Center of St Maries		STREET ADDRESS, CITY, STATE, ZIP CODE 820 Elm Street St Maries, ID 83861	

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure two of two residents and their resident representatives (Resident (R) 8, and R52) reviewed for emergent hospital transfer out of a total sample of 18 residents were provided with a written bed hold policy and transfer notice. This failure had the potential to affect the resident and their resident representative (RR) by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include:1. Review of R8's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R8 admitted to the facility on [DATE]. Review of R8's quarterly 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated severely impaired cognition.Review of R8's Progress Note, located in the EMR Progress Notes tab and dated [DATE], revealed that R8 was transferred to the hospital due to abnormal critical labs and returned to the facility on [DATE]. According to documentation the facility called a contact on file and left a message to return call to the facility. R8's Power of Attorney (POA) did return the call. The was no documentation that the transfer notice and bed hold were provided. 2. Review of R52's admission Record under the Profile tab in the EMR revealed R52 admitted on [DATE]. Review of R52's Medicare 5-day MDS, located in the EMR MDS tab, with an ARD of [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition.Review of R52's Progress Note, located in the EMR Progress Notes tab and dated [DATE], revealed that R52 was transferred to the hospital due to uncontrollable pain and returned to the facility on [DATE]. The was no documentation that the transfer notice and bed hold were provided.Review of R52's Progress Note, located in the EMR Progress Notes tab and dated [DATE], revealed that R52 was transferred to the hospital with shortness of breath (SOB), tremors to both arms, and oxygen saturation levels below 88%. R52 later expired at the hospital. According to documentation, the family was notified. The was no documentation that the transfer notice and bed hold were provided. During an interview on [DATE] at 2:00 PM, the Administrator confirmed that they had not sent the bed hold notices for R8 and R52.Review of the facility's policy Transfer and discharge date d [DATE] revealed, .Contents of written notice:1. The written notice of transfer/discharge includes:g. Reason for transfer/ dischargeh. Effective date of transfer/ dischargei. Location to which the resident is transferred/ discharged j. Statement that the residents have the right to appeal the action to the state.k. Name, address and telephone number of the state long term care ombudsman, andl. As applicable, mailing address and telephone number of the agency responsible for protection and advocacy of developmentally disabled or mentally ill individuals.m. Sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.Review of the facility's policy Bed-Holds and Returns dated [DATE] revealed, . Residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents regardless of payor source, are provided with written (continued on next page)

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

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

Printed: 06/25/2026
Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135075	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Vista Care Center of St Maries	820 Elm Street St Maries, ID 83861

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notice about these twice: a. notice 1: well in advance of any transfer (e.g., in admission packet): and b. notice 2: at the time of transfer (or if the transfer was an emergency, within 24 hours).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy, the facility failed to provide assistance with showering for two of three residents (Resident (R) 45 and R16) reviewed for activities of daily living (ADLs) out of a total sample of 18. This failure increased the potential for R45 and R16 to have unmet hygiene needs.Findings include:1. During initial rounds on 05/05/26 starting at 11:00 AM an observation of R45 revealed R45 appeared to have flaky skin, and her hair appears greasy and in need of a wash.During an interview on 05/05/26 at 1:50 PM, Family Member (F) 1 stated, R45 was not getting showers. F1 stated R45 was supposed to get three showers/baths per week but she's lucky to get one. F1 stated staff were not getting R45 dressed in the mornings. F1 presented a calendar to writer that the family was documenting showers R45 received. F1 stated that R45 only received four showers total for the month of April.Review of R45's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R45 was admitted to the facility on [DATE] with diagnoses that included Type 3 traumatic spondylolisthesis (displacement of vertebra) of 2nd cervical vertebra fracture routine healing, unspecified dementia, and spinal stenosis cervical region (abnormal narrowing of the spine).Review of R45's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/26, located under the MDS tab of the EMR, revealed R45 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated R45 had moderate cognitive impairment. It was recorded R45 required substantial/maximal assistance for showering/bathing. No documentation of refusing care.Review of R45's care plan, located in the EMR under the Care Plan tab, dated 08/06/24, revealed R45 had an ADL self-care performance deficit related to impaired balance, limited mobility, limited range of motion (ROM), and pain in neck. Further review of the care plan, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative.2. During initial rounds on 05/05/26 starting at 11:00 AM an observation of R16 revealed R16's hair appeared to need to be washed, her hair was waist length and appeared greasy at the crown of head.During an interview on 05/05/26 at 3:10 PM, R16 stated, I'm not getting my showers or baths, I'm supposed to get three a week, I'm lucky if I get one. They say they are short-staffed, but they're sitting around.During an interview on 05/06/26 at 9:30 AM, R16 stated, They won't give me a shower. They say they don't have a bath team. Review of R16's admission Record, located in the EMR under the Profile tab, revealed R16 was admitted to the facility on [DATE] with diagnoses that included Quadriplegia C5-C7, Bipolar disorder, spinal stenosis. Review of R16's quarterly MDS with an ARD of 04/15/26, located under the MDS tab of the EMR, revealed R16 had a BIMS score of 15 out of 15, which indicated R16 was cognitively intact. It was recorded R16 required partial/moderate assistance for showering/bathing. No documentation of refusing care. Review of R16's care plan, located in the EMR under the Care Plan tab, dated 11/03/23, revealed R16 had an ADL self-care performance deficit related to incomplete quadriplegia. Further review of the care plan, revealed no recorded concerns with rejection of care related to ADLs, including showering, nor that the resident only responded to questions in the negative.During an interview on 05/08/26 at 3:00PM, the Director of Nursing (DON) and Administrator revealed they were aware that staff members felt they were short-staffed if there was not a bath team. They stated the certified nurse aides (CNAs) were unaccustomed to giving baths to their residents and did not give baths or groom residents if the bath team was unavailable. They stated that the prior DON never had room assignments for CNAs they all looked after all residents so there was no accountability. The DON stated that since she arrived about six weeks ago, CNAs had assigned rooms and were being held accountable for their residents' care.Review of the facility's policy titled, Activities of Daily Living, Documentation Flow Sheet, last revised April 2025, revealed, Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.The refusal and details of the interventions refused are documented in the resident's clinical record.

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(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. Based on observation, staff interviews, and policy review, the facility failed to discard expired medications stored in one medication room storage refrigerator of one medication room. This deficient practice resulted in outdated medications remaining available for use. Findings include:Observation of the medication storage room refrigerator with the Minimum Data Set Coordinator (MDSC) on 05/07/26 at 11:35 AM revealed the following medications were expired. -One Lispro Insulin 100 units/milliliter (ml) vial had an expiration date of 01/23/26. There was no open date on the vial. -One Lantus Insulin 100 units/ml vial had an expiration date of 01/23/26. There was no open date on the vial. -One Apidra Solostar Insulin 100 units/ml injection pen had an expiration date of 02/04/26. -Trulicity (medication used to manage blood sugar levels) 3 milligrams (mg)/0.5 ml injection pen had an expiration date of 01/16/26 (Two injection pens left in the carton of four). There was no open date on the medication carton. -Gabapentin (anticonvulsant medication for seizures and pain) 250 mg/5ml solution (a 500 ml bottle with 450ml remaining) had an expiration date of 10/02/23. There was no open date on Gabapentin bottle. During an interview at the time of observation, the MDSC confirmed the medications stored in the storage refrigerator were expired and stated Licensed Practical Nurse (LPN) 1 was responsible for monitoring medication expiration dates for medications stored in the storage refrigerator. During an interview 05/07/26 at 12:59 PM, the Director of Nursing (DON) stated she did not think that anyone was assigned to go over the medication storage refrigerator and check for expired medications. The DON further stated that in the future a routine system to remove expired medications would be in place. The DON stated the expired medications should have been destroyed by staff or returned to the pharmacy for disposal.During an interview on 05/08/26 at 2:40 PM, LPN1 stated she reviewed all medication carts for expired medications but did not check the medications stored in the refrigerator. Review of the facility's policy titled, Administering Medications with revision date of April 2019 indicated, Medications are administered in a safe and timely manner, and as prescribed, under item 12, indicated the expiration/beyond use date on the medication label is checked prior to administration. When opening a multi-dose container, the date opened is recorded on the container.Review of the facility's policy titled, Discarding and Destroying Medications with revision date June 2025 indicated, under item 8, indicated for unused, non-hazardous controlled substances not disposed of by an authorized collector the EPA [Environmental Protection Agency] recommends destruction and disposal of the substance with other solid waste. Review of the facility's undated policy titled, Medication Labeling and Storage, indicated, under Medication Storage item 3, if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Under Medication Labeling under item 5, it is indicated that . are dated or discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Under item 6, indicated multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.