STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135076	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Nursing and Rehabilitation	46 North Midland Boulevard Nampa, ID 83651

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility's CNA job description, record review, and resident and staff interview, the facility failed to ensure dignity of residents when staff enter their rooms without knocking and waiting for acknowledgement to enter. This was true for 1 of 2 residents (Resident #64) reviewed for respect and dignity. This deficient practice placed residents at risk of embarrassment and diminished sense of self-worth. Findings include:The facility's Certified Nursing Assistant Job Description dated 12/17/21, documented staff are to knock before entering the resident's room. Resident #64 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including stroke and muscle weakness. On 9/22/25 at 12:38 PM, observed CNA #1 say the words knock, knock as he was walking down the hallway and then entered Resident #64's room without waiting to be invited into the room. On 9/22/25 at 12:40 PM, Resident #64 stated she expects the staff to knock on the door and wait to be invited into her room, not just say knock, knock and walk in. On 9/22/25 at 4:30 PM, observed CNA #1 say knock, knock as he was walking toward room [ROOM NUMBER] and then walk into resident room [ROOM NUMBER] without waiting to be invited into the room.On 9/22/25 at 4:35 PM, CNA #1 stated he should be knocking on the door and waiting to be invited into the room and had not.On 9/22/25 at 4:40 PM, the DON stated staff should be knocking on resident's doors and waiting to be invited into the room and had not been.

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an Advance Directive. This was true for 3 of 23 Residents (#12, #72 and #88) whose records were reviewed for Advance Directives. This deficient practice created the potential for harm or adverse outcomes if the resident's wishes were not followed or documented regarding their advance care planning. Findings include: The CMS SOM, Appendix PP, dated 7/23/25, defined: - Advanced Directive, as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State.) - Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive. 1.) Resident #12 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including stroke and diabetes. Resident #12's ACKNOWLEDGMENT OF PATIENT INFORMATION ON ADVANCED DIRECTIVES was completed on the day of admission, 2/3/25, and documented resident did not want to create an Advanced Directive at that time. Resident #12's Electronic Medical Record (EMR) contained a POST on file dated 9/9/24. The EMR did not contain documentation of an Advanced Directives, or documentation Advanced Directives were discussed with her. On 9/24/25 at 3:40 PM, the Social Worker #2 stated she has not asked Resident #12 about formulating an Advanced Directive specifically because she thought the POST was the same as an Advanced Directive. 2.) Resident #72 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic respiratory failure, diabetes, and chronic pain. Resident #72's ACKNOWLEDGMENT OF PATIENT INFORMATION ON ADVANCED DIRECTIVES was completed on the day of admission 9/26/24, and documented resident did not want to create an Advanced Directive at that time. Resident #72's EMR contained a POST on file dated 4/17/24. The EMR did not contain documentation of an Advanced Directives, or documentation Advanced Directives were discussed with her. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/25 at 3:45 PM, the Social Worker #2 reviewed Resident #72's EMR and stated she had not followed up on the Advanced Directive because Resident #72 had a POST in place, and Social Worker #2 thought they were the same thing. 3.Resident #88 was admitted to the facility on [DATE] with multiple diagnoses including cerebral infarction (process that causes tissue death in the brain) and dementia. Resident #88's medical record contained a POST but did not contain documentation the facility had provided information on formulating an advance directive as requested by the resident/resident representative in the admission packet. On 9/23/25 at 12:31 PM, Social Services staff #1 stated the facility only had a POST document for Resident #88 and had no documentation the information on formulating an advance directive requested by the resident/resident representative in the admission packet had been provided or followed up on since admission to the facility. On 9/24/25 at 4:17 PM, Social Services staff #2 stated the facility had no documentation for Resident #88 that the facility had followed up on advance directives during the quarterly meetings.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to provide the Advance Beneficiary Notice (ABN - CMS-10055 form) for 2 of 3 residents (#19 and #70) reviewed for beneficiary protection notification. This deficient practice had the potential to cause financial harm or distress for residents when they were not informed of their potential liability for payment when their Medicare Part A benefits ended. Findings include: 1. Resident #19 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including amputation aftercare and malnutrition.A Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form documented beginning on 5/20/25, Resident #19 would have to pay out of pocket for his care. Resident #19 had not signed the document until 5/29/25, 9 days after the cares were being provided.2. Resident #70 was initially admitted to the facility on [DATE], and was readmitted on [DATE], with multiple diagnoses including left femur fracture and pulmonary fibrosis (a chronic lung disease characterized by the scarring and thickening of the lungs' interstitial tissue leading to shortness of breath and fatigue).A Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage form documented beginning on 6/28/25, Resident #70 would have to pay out of pocket for his care. Resident #70 had signed the document, and it was not dated when it was signed.On 9/25/25 at 10:55 AM, the DON stated the ABNs should have been signed and dated by Resident #19 and Resident #70 prior to providing cares for which either resident could be billed for.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, review of the Bureau of Facility Standards Long Term Care Reporting System (BFS) portal and staff interview, it was determined the facility failed to report allegations of potential abuse to the State Survey Agency within 2 hours. This affected 1 of 2 residents (Resident #3) whose records were reviewed for abuse reporting and investigation. This deficient practice created the potential for harm if allegations were not acted upon in a timely manner and the abuse continued. Findings include:The facility Reporting Alleged Violations of Abuse, Neglect, Exploitation, or Mistreatment policy revised April 2025, documented under Procedure: In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will:a. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment.are reported immediately but:Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury.Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury.b. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment .are reported to:The Administrator of the FacilityThe State Survey AgencyAdult Protective Services (as appropriate)Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cerebral palsy (a group of disorders that affect movement, muscle tone, and posture due to damage to the developing brain) and chronic obstructive pulmonary disease (a group of lung diseases that cause progressive airflow obstruction and breathing difficulties).The complaint documented on 6/9/25 around 1:30 PM, CNA #3 observed CNA #1 roughly slam Resident #3 into the wall when turning her in the bed. CNA #3 reported this to the hall nurse and texted RN #1 nurse manager regarding the alleged abuse. CNA #3 did not report the alleged abuse to the Administrator until 6/11/25 at 1:00 PM. The Administrator had not reported the alleged abuse to the state survey agency or BFS portal. On 9/24/25 at 11:30 AM, the Administrator stated she had not reported the alleged abuse to the BFS portal within 2 hours and should have.

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F 0689 Level of Harm - Minimal harm or potential for 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 review of state operations manual, observation, and interviews, it was determined the facility failed to ensure residents were provided with a safe homelike environment. This was true for 1 of 3 residents (Resident #64) whose rooms were observed. This deficient practice created the potential for diminished quality of life and water temperature burn risk. Findings include:State Operations Manual Appendix PP, revised 7/23/25, documented water temperature of 124 degrees F will cause a 3rd degree burn to occur within 3 minutes, and water temperatures of 120 degrees F will cause a 3rd degree burn to occur within 5 minutes. On 9/22/25 at 12:40 PM, Resident #64 in room [ROOM NUMBER] stated the room sink water gets very hot.On 9/22/25 at 4:15 PM, the sink water temperature in room [ROOM NUMBER] was 122 degrees F.On 9/22/25 at 4:18 PM, the sink water temperature in room [ROOM NUMBER] was 123 degrees F.On 9/22/25 at 4:20 PM, the sink water temperature in room [ROOM NUMBER] was 124 degrees F.On 9/22/25 at 4:30 PM, the DON stated the room sink water temperature should not be above 115 degrees F.On 9/22/25 at 4:55 PM, the assistant maintenance director stated the room sink water temperature should not be above 115 degrees F and he was going to do some testing.On 9/23/25 at 10:11 AM, the DON stated as for the water policy, the facility follows the regulation and checks water temperatures routinely. On 9/23/25 at 10:30 AM, the surveyor verified the calibration reading of his water temperature gauge by testing room [ROOM NUMBER] sink water temperature along with the maintenance director temperature gauges which had the same reading of 114 degrees on this day.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician. This was true for 1 of 4 residents (Resident #98) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue and low oxygen levels. Findings include: Resident #98 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's disease (a progressive neurodegenerative disorder characterized by the gradual loss of dopamine-producing neurons in the brain leading to a range of motor and non-motor symptoms, including tremors, rigidity, slowness of movement and difficulty with balance and coordination) and chronic obstructive pulmonary disease (a group of lung diseases that cause progressive airflow obstruction and breathing difficulties).Resident #98's medical record had two physician orders for oxygen therapy as follows: - active order dated 12/23/24, documented O2 via NC at 2L-4 Lpm if O2 saturation is less than 90%. - active order dated 1/4/25 2 Lpm oxygen via nasal cannula at bedtime.On 9/23/25 at 8:49 AM, observed Resident #98 in his room sitting in his wheelchair with CNA #2 assisting him with his ADLs, without his oxygen cannula in his nose. The oxygen concentrator was running however all the oxygen tubing was in a plastic bag hanging on the oxygen concentrator. On 9/23/25 at 8:50 AM, observed Resident #98 was lethargic, not responding to most questions or prompts from CNA #2 while he was off his oxygen.On 9/23/25 at 8:51 AM, CNA #2 stated she had just moved Resident #98 into his wheelchair and would reapply his oxygen after finishing getting him ready for the day.On 9/23/25 at 9:00 AM, LPN #1 stated Resident #98 had to use oxygen during the day over the weekend due to SOB and low SpO2 and should be on his oxygen at 2 Lpm and she would check his SpO2. On 9/23/25 at 9:02 AM, LPN #1 stated Resident #98 had not stated he felt SOB but acknowledged he was acting confused and lethargic which is an indication of low SpO2. On 9/23/25 at 9:04 AM, LPN #1 stated Resident #98 oxygen level was low at 81% on room air and she applied the oxygen at 2 Lpm and had to increase the oxygen flow up to 4 Lpm to get the resident SpO2 above 90%. On 9/23/25 at 9:10 AM, LPN #1 stated she instructed CNA #2 to notify the LN if residents act lethargic, are not responding to prompts, and appear to be SOB so the LN can properly assess the resident.On 9/25/25 at 10:00 AM, the DON stated residents that appear lethargic and are not responding to verbal prompts should be assessed by a LN for low SpO2 and had not been.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was identified the facility failed to ensure residents were properly monitored for pain management. This was true for 2 of 4 residents (#8 and #72) whose records were reviewed for pain management. This failure had the potential to create harm when residents were not monitored adequately for pain. Findings include:The Idaho Board of Medicine report, The Appropriate Role of Unlicensed Medical Personnel, (Winter 2012/2013), documented that unlicensed personnel are not permitted to exercise independent judgment, provide assessments, interpretations or diagnoses, or perform invasive procedures. 1. Resident #8 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including myositis (an inflammation of the muscles) and dyspnea. Resident #8's medical record contained a physician order dated 9/2/25, for hydrocodone-acetaminophen oral tablet 7.5-325 MG to be given every four hours as needed for pain. Resident #8's MAR documented on 9/21/25 at 9:41 PM, the MAC documented Resident #8's pain level was 5 and she administered hydrocodone-acetaminophen oral tablet 7.5-325 MG. Resident #8's medical record had not contained any LN assessment of pain related to administration of this medication on 9/21/25 at 9:41 PM. On 9/23/25 at 7:31 AM, the DON stated that a licensed nurse should have documented their pain assessment of Resident #8 prior to the MAC giving Resident #8 the hydrocodone-acetaminophen oral tablet 7.5-325 MG but had not. 2.) Resident #72 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic respiratory failure, diabetes, and chronic pain. Resident #72's Quarterly MDS Assessment, dated 9/8/25, documented she was cognitively intact. Resident #72's care plan, revised on 3/11/25, documented the following interventions for pain: - Administer analgesic medication as per orders - Pain assessment every shift - Position for comfort A physician's order dated 4/17/24, directed staff to monitor level of pain every shift using the following scale: 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, 7-10 = severe pain A physician's order dated 5/5/25, directed staff to administer oxycodone (a narcotic pain medication) 5/325 MG, one-tablet by mouth every 6 hours as needed for moderate to severe pain. Review of Resident #72's Medication Administration Record (MAR) for September 2025, documented oxycodone was administered when her pain assessment was zero on the following dates. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/5/25 at 1:59 AM - 9/6/25 at 2:44 AM - 9/7/25 at 1:41 AM - 9/11/25 at 2:24 PM - 9/12/25 at 2:44 AM - 9/13/25 at 4:20 AM - 9/14/25 at 2:38 AM - 9/18/25 at 7:06 PM - 9/19/25 at 2:24 AM - 9/20/25 at 2:27 AM On 9/24/25 at 10:27 AM, the DON reviewed Resident #72's medical record and confirmed the oxycodone should only be administered as needed for a pain rating of 4 or higher to meet the order for moderate to severe pain and that the nurses needed to document better when administering as needed pain medications.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on review of the State Operations Manual, Appendix PP, observation, and staff interview, it was determined the facility failed to ensure the daily nurse staffing information was accurately posted for each shift. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's current staffing levels. Findings include:On 9/25/25 at 10:17 AM, the daily postings of licensed and unlicensed nurse staffing dated 3/20/25 - 9/20/25 was reviewed. There were no adjustments to the posted staffing when the scheduled hours did not match the actual hours worked.On 9/24/25 at 11:00 AM, the Human Resource Manager stated she was not aware the actual hours worked by the nursing staff had to be documented on the daily posting of licensed and unlicensed nurse staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on Policy review, observation, record review, and staff interview, it was determined the facility failed to ensure narcotic counts were consistently verified by the off going and on coming nurses. This was true for 3 of 3 medication carts. This failure created the potential for undetected misuse and/or diversion of controlled medications and the potential for harm if a controlled medication was not available when needed. Findings includeThe facility's Policy and Procedure regarding Controlled Drugs revised 4/2025, documented, A reconciliation or physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record at each shift change. 1) The C - Hallway medication cart narcotic count sheet documented the following:* 9/24/25: 6:00 AM - the oncoming nurse signature space was blank.On 9/24/25 at 8:15 AM, LPN #2 confirmed the signature space for the oncoming nurse was blank and he stated he must have simply forgot to sign the log after the count that morning. 2) The Special Care Unit (SCU) - Hallway medication cart narcotic count sheet documented the following:* 9/24/25: 6:00 AM - the oncoming nurse signature space was blank.On 9/24/25 at 8:40 AM, LPN #1 confirmed the signature space for the oncoming nurse was blank and she stated she forgot to sign the log. 3) The A- Hallway medication cart narcotic count sheet documented the following:* 9/24/25: 6:00 AM - the off going nurse signature space was blank.On 9/24/25 at 9:25 AM, RN #3 confirmed the signature space for the off going nurse was blank but said she must have forgot to sign the log because the off going nurse signed in her spot by mistake. On 9/24/25 at 10:00 AM, the DON stated the expectation is for the off going and oncoming nurse to perform a narcotic count for the cart they are assigned to and sign the log when those counts are done.

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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 policy review, observation, and staff interview, it was determined the facility failed to ensure medications were secure and inaccessible to unauthorized staff and residents. This failed practice created the potential for harm to a resident if they were to obtain medications which were left unattended and unsecured by staff. Findings include: The facility's Policy and Procedure regarding Controlled Drugs revised 4/2025, documented, It is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse using separately locked, permanently affixed compartments.On 9/24/25 at 8:00 AM, with RN #2 present, observed the following in C Hallway medication storage room: -narcotic storage refrigerator was unlocked and unmonitored-a black metal box inside the refrigerator labeled Hall C Narcotic Box was not permanently affixed inside the refrigerator.On 9/24/25 at 8:04 AM, RN #2 stated, the narcotic fridge should not have been left unlocked, and the C-Hall narcotic box should have been secured inside the fridge.On 9/24/25 at 8:20 AM, the DON stated, the expectation is that the narcotic refrigerator is to remain locked, but in instances where the door is left unlocked, the narcotics inside are locked and secured to the inside. When asked about the C-Hall Narcotic Box, he removed it from the refrigerator and stated it should have been locked securely to the inside of the refrigerator.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of the Idaho Food Code, the facility failed to ensure staff wore beard nets in the kitchen and appropriately stored, distributed, and labeled foods. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food-borne illnesses. Findings include:The Idaho Food Code, revised February 2021, 2-402.11 listed under hair restraints documented, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens.The Idaho Food Code, revised February 2021, documented, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. On 9/22/25 at 12:30 PM, observed the assistant dietary manager in the kitchen food prep areas without a beard cover over his facial hair. On 9/22/25 at 12:35 PM, the assistant dietary manager stated he did not think he needed a beard cover because his facial hair was short. On 9/22/25 at 12:40 PM, observed an opened bottle of red food coloring not labeled with the opened date. On 9/22/25 at 12:52 PM, the assistant dietary manager stated all food items should be labeled with the opened and used by dates and were not. On 9/22/25 at 12:25 PM, during the initial dining observation, a carafe of cranberry juice with a use by date of 9/21/25 was being served to residents in the Bistro dining room. On 9/22/25 at 12:27 PM, RN #3 was asked about the use by date on the cranberry juice. She stated it should not be used if the date is past the use by date. On 9/22/25 at 12:13 PM, during the dining room observation, three containers of dry cereal with a use by date of 9/19/25 was available for residents' use on the back counter in the C dining room. On 9/22/25 at 12:31 PM, LPN #2 was asked about the use by date on the dry cereal containers. He stated it should not be used if the date is past the use by date. On 9/22/25 at 12:47 PM, [NAME] #1 removed the dry cereal containers and stated the cereal should have been removed and had not been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135076	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow View Nursing and Rehabilitation	46 North Midland Boulevard Nampa, ID 83651

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 - Few	Provide and implement an infection prevention and control program. Based on observation, staff interviews, and record review, it was determined the facility failed to ensure clean clothing were stored on a clean surface in the laundry area. This deficient practice created the potential for harm due to the increased risk of cross contamination and had the potential to affect all residents in the facility. Findings include:The facility's policy for Infection Prevention and Control Program, dated 06/2021 with revision/review date 04/2025, documented the following: The Infection Prevention and Control Program is a facility-wide effort involving all disciplines and individuals.process surveillance includes linen management (handling, storage, processing, and transport) .On 9/24/25 at 1:27 PM and 9/25/25 at 10:21 AM, observed in the laundry room multiple clear unsealed plastic bags on the floor near the washing machines containing folded clothing. On 9/24/25 at 1:36 PM, Laundry staff #1 stated the clothing in the bags are clean and were placed on the floor when staff returned from the laundromat and was trying to get the clean clothes sorted and returned to the residents but should not have placed the bags of clothing on the floor. On 9/25/25 at 10:23 AM, Laundry staff #2 stated the clothing in the bags are clean and should not have been placed on the floor.On 9/24/25 at 1:49 PM, the Executive Director stated she was aware of the issues with the laundry room washing machines not functioning, and the facility had been using outside laundry services which caused additional work for the staff to get the clean laundry back to the residents.