

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Valley View Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1140 North Allumbaugh Street Boise, ID 83704	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to maintain a clean and homelike environment for 1 of 1 resident (Resident #2) reviewed for environmental conditions. This failure created the potential for embarrassment and psychosocial harm when Resident #2's room was repeatedly observed to have a foul urine odor and unclean conditions. Findings include:Resident #2 was readmitted to the facility on [DATE], with multiple diagnoses including end stage heart failure, cirrhosis of the liver, and immunodeficiency.A social services progress note created on 9/8/25 at 3:51 PM, documented that on 9/8/25 at 7:47 AM, the Licensed Social Worker identified Resident #2's room to be cluttered and uncleanly. She documented she provided education to Resident #2 about decluttering his room and allowing the housekeeper to clean his room.A social services progress note dated 9/8/25 at 7:18 PM, documented when Resident #2 left the facility housekeeping services were provided. During the services provided, it was identified Resident #2 had multiple half eaten old food items, sticky residue all over his dresser, and bedside table. On 9/8/25 at 3:01 PM, during a hall observation, room [ROOM NUMBER] was located at the end of the hallway. Upon approaching the room, a foul odor was noted. Resident #2's room was observed to have sticky floors, visible wheelchair track marks, and a strong urine odor.On 9/8/25 at 3:11 PM, LPN #1 stated the odor was urine and that staff attempt to empty urinals to reduce the smell. She stated Resident #2 sometimes spills urine on himself, contributing to the odor.Resident #2's room was observed to have a foul urine smell on the following dates and times:9/8/25 at 3:01 PM9/9/25 at 11:39AM9/10/25 at 9:53 PM9/11/25 at 9:12 [NAME] 9/11/25 at 9:18 AM, Housekeeper #1 confirmed that Resident #2's room had a persistent urine odor. She stated that as of 9/8/25, she had been instructed to clean room [ROOM NUMBER] twice daily. Prior to that date, the room was cleaned once daily. She reported that despite cleaning, the room would smell like urine again by the end of the day and showed visible wheelchair marks on the floor.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 135098	Facility ID: 135098 If continuation sheet Page 1 of 17

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure resident's right were protected to be free from abuse. This was true for 1 of 1 resident (Resident #87) reviewed for abuse. This failure caused harm to Resident #87 and placed all residents at risk for ongoing abuse and potential physical and psychosocial harm. Findings include: The facility's Reporting Reasonable Suspicion of a Crime policy revision date April 2025, documented it was the policy of the facility to protect its residents from abuse, neglect, exploitation, and misappropriation of resident property. Resident #87 was admitted to the facility on [DATE], with the multiple diagnoses including parkinson's and dementia. Review of Resident #87's quarterly MDS, dated [DATE], indicated Resident #87 had a BIMS (Brief Interview For Mental Status) of 15, indicating no cognitive impairment. Resident #113 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (when blood flow to the brain is interrupted, leading to cell death and brain damage) and anxiety. A review of Resident #113's discharge MDS dated [DATE], indicated he had a BIMS of 15, indicating no cognitive impairment. A Nurse Practitioner note dated 1/17/25, documented Resident #113 stated that while he was out of facility, he was having significant anxiety and restlessness with suicidal ideations with a plan for self-harm and means to carry this out. Now that he is in the facility, he feels safe but continues to have fluctuating moods and behaviors with anxiety, he has declined to restart citalopram (an antidepressant medication). A Nurses Notes dated 3/7/25 at 12:43 PM, documented Resident #113 approached the nurse for a Norco (opioid pain medication). The nurse explained to Resident #113 that his Norco was not due until 2 AM. The nurse offered Tylenol, and he declined it. Resident #113 stated that he needed to get out of the building so he can self-medicate. The nurse reminded Resident #113 that he was on a pain contract and that it needed to be followed. Resident #113 then told the nurse that she better have his pain pill at 2:00 AM, and she better not be late. Resident #113 then stated the nurse better not write any notes on him or else. Resident #113's Behavior Noted dated 3/8/25, documented he approached the nurse and told the nurse I am going to leave this place I am tired of waiting for you to give me my meds. Resident #113 then told the nurse he was going to go to the overpass, jump in front of the first diesel truck he could find and kill himself. The nurse asked the patient to clarify his intentions, and the patient repeated that if he did not get his goddamn pills, that he was going to kill himself. The nurse then requested he remain at the first-floor nurses' station and CNAs monitored Resident #113 from a safe distance while the nurse contacted and spoke to the second-floor nurse regarding this change in cognition and the statement he had made. A facility incident report, dated on 3/13/25 at 4:30 PM, documented Resident #113 was observed hitting Resident #87 in the face causing bruising and facial laceration to left orbital area with redness to the sclera and nose. The facility's incident report documented the following immediate actions were taken: Residents were separated. Both residents assessed for injuries and treated as needed. Resident #113 was placed on 1:1 observation. Police were notified and Resident #113 was arrested. Psychosocial evaluation was completed on Resident #87 with no additional findings. Residents were interviewed and no reported concerns were noted. Resident #87 and Resident #113's family resident representative were notified of the incident. On 9/10/25 at 3:52 PM, the Executive Director stated the resident-to-resident abuse did happen and the staff immediately separated the residents.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, staff interviews, and Bureau of Facility Standards Long-Term Care Reporting Portal, it was determined the facility failed to ensure interventions were implemented to prevent further resident to resident abuse incidents. This was true for 2 of 5 (Resident #87 and #113) reviewed for resident-to-resident abuse. This failure created the potential to cause psychosocial, verbal, and physical harm to residents residing in the facility. Findings include: The facility's Reporting Reasonable Suspicion of a Crime policy revised April 2025, documented it is the policy of the facility to protect resident from abuse, neglect, exploitation, and misappropriation of resident property. The facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation, or Mistreatment policy revised April 2025, documented it is the policy of the facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the residents, resident representatives, families, friends, or other individuals. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: Ensure that if the alleged violation is verified, and appropriate corrective action is taken. Depending on the nature of the allegation, immediately put effective measures in place to ensure that further potential abuse, neglect, mistreatment, exploitation, or misappropriation of resident's property does not occur while the investigation is in process. Assess the corrective action taken, if any, in response to the results of the investigation to determine its effectiveness. Resident #87 was admitted to the facility on [DATE], with the multiple diagnoses including Parkinson's and dementia. Review of Resident #87's quarterly MDS dated [DATE], indicated Resident #87 had a BIMS of 15, indicating no cognitive impairment. Resident #113 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (when blood flow to the brain is interrupted, leading to cell death and brain damage) and anxiety. Review of Resident #113's discharge MDS dated [DATE], indicated Resident #113 had a BIMS of 15 indicating no cognitive impairment. A Nurse Practitioner note dated 1/17/25, documented Resident #113 stated that while he was out of facility, he was having significant anxiety and restlessness with suicidal ideations with a plan for self-harm and means to carry this out. Now that he is in the facility, he feels safe but continues to have fluctuating moods and behaviors with anxiety, he has declined to restart citalopram. A Nurses Notes dated 3/7/25 at 12:43 PM, documented the Resident #113 approached the nurse for a Norco (opioid pain medication). The nurse explained to Resident #113 that his Norco was not due until 2 AM. The nurse offered Tylenol, and he declined it. Resident #113 stated that he needed to get out of the building so he can self-medicate. The nurse reminded Resident #113 that he was on a pain contract and that it needed to be followed. Resident #113 then told the nurse that she better have his pain pill at 2 AM, and she better not be late. Resident #113 then stated that the nurse better not write any notes on him or else. Resident #113's Behavior Noted dated 3/8/25, documented he approached the nurse and told the nurse that I am going to leave this place I am tired of waiting for you to give me my meds. Resident #113 then told the nurse that he was going to go to the overpass, jump Infront of the first diesel truck he could find and kill himself. The nurse asked the patient to clarify his intentions, and the patient repeated that if he did not get his goddamn pills. that he was going to kill himself. The nurse then requested he remain at the first-floor nurses' station and CNAs monitored Resident #113 from a safe distance while the nurse contacted and spoke to the second-floor nurse regarding this change in cognition and the statement he had made. A facility reported incident documented on 3/13/25 at 4:30 PM, Resident #113 was observed hitting Resident #87 in the face causing bruising and facial laceration to left orbital area with redness to the sclera and nose. Immediate action taken:- Residents were separated.- Both residents assessed for injuries and treated as needed.- Resident #113 was placed on 1:1 observation.- Police were notified. Resident #113 was arrested.- Psychosocial evaluation completed on Resident #87 with no additional findings.- Like residents were interviewed and no reported concerns noted.- Family/POA notified for Resident #87 and Resident #113. On 9/10/25 at 3:13 PM, the Administrator stated he thought by Resident #113 being arrested, the facility had put an intervention in place. He also stated there were no other interventions put in place to prevent further potential resident-to-resident abuse.		

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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 policy review, record review, and staff interviews it was determined the facility failed to ensure pertinent health information was provided to the receiving health facility for 2 of 6 residents (Resident #4 and #79) reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if the residents were not treated in a timely manner due to a lack of information provided upon transfer. Findings include: The facility's Criteria for Transfer and Discharge policy, revised December 2023, documented when the facility transfers or discharges a resident, the facility shall ensure the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. 1. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and anxiety. a) A Nurses Note dated 3/20/25, documented Resident #4 was non-responsive, with no verbal response, and pupils were pinpoint and non-reactive to light. Resident #4 developed right sided weakness. The NP (Nurse Practitioner) was notified, and an order was received to transport Resident #4 to the hospital. An eINTERACT Transfer Form (an electronic tool that helps long-term care facilities effectively communicate critical resident information when transferring them to an acute care hospital) dated 3/21/25, documented Resident #4's representative was notified. Resident #4's record did not include documentation that pertinent medical information was provided to the receiving hospital for his 3/20/25 discharge. b) A Nurses note dated 6/4/25, documented the nurse was notified that Resident #4 was tremoring, not responding verbally, his pupils were fixed and pinpoint, he had no strength to right hand, and his pulse was rapid and irregular. The NP was notified, and orders were given to transport Resident #4 to the hospital for evaluation of possible Cerebral Vascular Accident or Seizure. Resident #4's sister was called, and a message was left on her phone. An eINTERACT Transfer Form, dated 6/4/25, documented Resident #4's sister was notified. Resident #4's record did not include documentation that pertinent medical information was provided to the receiving hospital. On 9/11/25, the CRN #1 stated the required forms were sent with Resident #4 to the hospital and report was called into the hospital, but it was not documented in his chart, and she was aware that it should have been documented. Resident #79 was readmitted to the facility on [DATE], with multiple diagnoses including partial paralysis following a heart attack, dementia, cirrhosis, depression, and anxiety. A nursing progress note, dated 8/28/25 at 9:27 PM, documented Resident #79 had slipped from her chair and bumped her head on the floor. She sustained a laceration with active bleeding to the right upper eyebrow. Staff call 911 and Resident #79 was sent out for further treatment and evaluation. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospital encounter note, dated 8/28/25, documented Resident #79 was seen due to a fall from a wheelchair. Resident #79 had the following initial encounter concerns identified: a closed fracture of one rib on her right side, ground-level fall, laceration of right eyebrow, and contusion of face. A nursing progress note, dated 8/29/25, documented Resident #79 had sustained a new injury to just above the outer region of the right eyebrow. Sutures were placed at the ER. Resident #79's record did not include documentation of the hospital transfer paperwork. On 9/11/25 at 10:34 AM, the DON stated there was no hospitalization paperwork from the facility to the hospital related to the 8/28/25 ER visit.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure residents' Minimum Data Set (MDS) had correct assessment information. This was true for 1 of 3 residents (Resident #10) reviewed for accuracy of MDS assessments. This deficient practice created the potential for residents to not receive appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial needs. Findings include:Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy (a movement disorder affecting the nervous system, causing problems with muscle control, movement, and posture) and major depressive disorder.On 4/30/25, Resident #10's physician order documented hydroxyzine HCL oral tablet 25 mg (anti-anxiety medication) by mouth at bedtime for anxiety.On 5/6/25, Resident #10's History and Physical documented to give hydroxyzine HCL 25 mg tablet by mouth at bedtime for anxiety.On 5/6/25, Resident #10's admission MDS, section I5700 (anxiety disorder) and section N0415B (anti-anxiety medication) was not marked, indicating she did not have a diagnosis of anxiety and was not taking an anti-anxiety medication.On 5/6/25, Resident #10's History and Physical documented she had a diagnosis of unspecified Dementia, severe.On 5/6/25, Resident #10's admission MDS, section I4200 (Alzheimer's Disease) and I4800 (Non-Alzheimer's Dementia) was not marked, indicating she did not have a diagnosis of Dementia.On 9/12/25 at 10:21 AM, the DON stated the MDS's dated 5/6/25 and 6/18/25 for Resident #10 did not include a diagnosis of dementia or her diagnosis and treatment of anxiety.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 professional standards of nursing practice were followed 1 of 2 residents (Resident #17) reviewed for anticoagulant (AC) monitoring. This deficient practice created the potential for harm if Resident #17's anticoagulant therapy was not monitored for signs and symptoms of complications. Findings include: Resident #17 was readmitted on [DATE], with multiple diagnoses including cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), atrial fibrillation (a common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly, which can cause the blood to pool in the atria and form clots, increasing the risk of stroke,) COPD (Chronic Obstructive Pulmonary Disease: a lung condition caused by damage to the lungs, leading to trouble breathing,) diabetes, schizophrenia, and high blood pressure. A physician order, dated 6/27/24, documented Resident #17 should be monitored for adverse reactions with his AC medication.A physician order, dated 2/24/25, documented Resident #17 was ordered to take Xarelto Oral Tablet 20 mg (Rivaroxaban; an anticoagulant (AC)); give 1 tablet by mouth in the morning related to atrial fibrillation.A review of Resident #17's care plan, initiated on 6/27/25, directed staff to monitor, document, and report to physician, as needed, signs and symptoms of anticoagulant complications. The Treatment Administration Record (TAR) reviewed July 2025 through September 2025, documented AC signs and symptoms were not monitored:PM Shift: 9/4/25 PM Shift: 8/7/25, 8/9/25, 8/28/25, 8/29/25 On 9/11/25 at 9:35 AM, the DON with CRN #1, stated the TAR should have been marked 'completed' on the dates in question.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and policy review, the facility failed to ensure physician orders were followed for 1 of 1 residents (Resident #72) reviewed for tube feeding. This failure created the potential for poor nutrition when the incorrect nutritional supplement was administered. Findings include: The facility's policy titled Medication Administration Via Feeding Tube, revised July 2025, directed staff to confirm the physician's order prior to administration. Resident #72 was admitted to the facility on [DATE] with multiple diagnoses including cancer of the mouth, cancer of the esophagus, and cancer of other unspecified sites. Resident #72's care plan, initiated on 8/24/25, documented tube feeding as ordered. A physician order dated 8/20/25 directed staff to administer Jevity 1.5 nutritional supplement at 125 milliliters per hour for 16 hours to provide a total of 2,000 milliliters daily. On 9/10/25 at 9:45 AM, Resident #72 was observed connected via PEG tube to a pump delivering Glucerna 1.5 nutritional supplement at 125 milliliters per hour. On 9/10/25 at 10:00 AM, Unit Manager #1 and LPN #2 confirmed that the nutritional supplement being administered was Glucerna 1.5. On 9/10/25 at 10:09 AM, the Unit Manager #1 stated Resident #72 had been given the incorrect nutritional supplement and that the physician's order had not been followed.		

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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. Based on observation, staff interviews, record review, and policy review, the facility failed to ensure oxygen therapy was provided as ordered by the physician for 1 of 2 residents (Resident #29) reviewed for oxygen therapy. This failure created the potential for adverse health outcomes, including poor oxygenation and impaired concentration, when Resident #29 was not receiving oxygen therapy as prescribed. Findings include:Resident #29 was admitted the facility on 7/15/25, with multiple diagnoses including chronic respiratory failure, respiratory disorder, and cognitive impairment.Resident #29's care plan, initiated 7/16/25, directed staff to provide oxygen as ordered.A physician order, dated 7/15/25, documented oxygen at 5 liters via nasal cannula continuously.A subsequent physician order dated 8/15/25 directed staff to wean oxygen therapy for oxygen saturation levels over 94%, and to administer 1-3 liters per minute via nasal cannula as needed to maintain oxygen saturation between 88-93%.On 9/10/25 at 9:03 AM, during a medication administration observation, Resident #29 was observed resting in bed without oxygen in place. RN #3 entered the room, administered medications, and then informed Resident #29 that she would be checking his oxygen saturation. RN #3 obtained a pulse oximeter and verbalized that Resident #29's oxygen saturation was 80% on room air. RN #3 then applied oxygen via nasal cannula.On 9/10/25 at 9:11 AM, RN #3 stated she would follow the physician's order dated 7/15/25 for continuous oxygen at 5 liters per minute via nasal cannula. She confirmed that Resident #29 was not wearing oxygen at the time of medication administration. When asked to describe the weaning process, RN #3 stated the oxygen flow would be gradually reduced and the resident would be monitored to ensure appropriate oxygen saturation levels. She confirmed the process did not involve removing oxygen entirely without monitoring.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to ensure the Medical Director and Director of Nursing Services acted upon pharmacist recommendations for 1 of 5 residents (Resident #90) reviewed for unnecessary medications. This failure created the potential for adverse effects and for residents to continue receiving medications without clinical justification. Findings include: The facility's policy titled Medication Drug Regimen Review, revised December 2023, documented that a medication regimen review (MRR) includes a review of the resident's medical chart. Identified irregularities are to be documented on a separate written report that includes the resident's name, the relevant drug, and the irregularity identified. The report is to be sent to the attending physician, the facility's Medical Director, and the Director of Nursing Services (DNS) to be acted upon. Resident #90 was admitted to the facility on [DATE], with multiple diagnoses including dementia, need for assistance with personal care, and Parkinson's disease. Resident #90's record included a pharmacy consultation report dated 5/1/25, which recommended discontinuation of the following medications due to lack of use in the past 60 days: Artificial tear drops, 1 drop in both eyes as needed for dry eyes. Triamcinolone acetonide 0.1% cream, applied topically as needed for skin irritation. On 9/11/25 at 8:15 AM, a request was made for documentation of the provider's response to the pharmacy consultation report. On 9/11/25 at 12:59 PM, the Director of Nursing stated that the pharmacy recommendation had not been acknowledged, and it was unclear whether the medications were still necessary.		

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NAME OF PROVIDER OR SUPPLIER Valley View Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1140 North Allumbaugh Street Boise, ID 83704	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews, the facility failed to ensure that residents were free from significant medication errors for 1 of 5 residents (Resident #50) observed during medication administration. This failure created the potential for harm when RN #3 did not assess Resident #50's apical pulse (a pulse point on your chest that gives the most accurate reading of your heart rate) prior to administering digoxin, a medication known to affect heart rate. Findings include:Resident #50 was readmitted to the facility on [DATE], with multiple diagnoses including cerebral infarction affecting the right dominant side, hypertension, and atrial fibrillation. A physician order, dated 3/14/25, documented digoxin 125 micrograms orally each morning for atrial fibrillation, with instructions to notify the provider for a heart rate less than 40 beats per minute. According to the Nursing Unbound Medicine website, accessed on 9/16/25, digoxin increases cardiac output and slows heart rate. The recommended assessment prior to administration includes monitoring the apical pulse for one full minute. If the heart rate is below 60 beats per minute, the dose should be held and the healthcare provider notified.On 9/10/25 at 8:27 AM, during a medication administration observation, RN #3 was observed taking Resident #50's vital signs using an electronic machine. RN #3 then prepared medications at the cart, including digoxin 125 micrograms. She placed one tablet into a medication cup and associated the pulse obtained from the machine with the administration of digoxin. When asked if she had obtained an apical pulse prior to administering digoxin, RN #3 stated no and returned the digoxin card to the cart. After gathering all medications, RN #3 entered Resident #50's room, performed hand hygiene, donned gloves, and proceeded with medication administration. No apical pulse was obtained prior to administering digoxin.On 9/10/25 at 10:00 AM, the DON stated that an apical pulse should be obtained prior to the administration of Digoxin.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on representative interview, record review, and staff interview it was determined the facility failed to ensure residents obtained routine and emergency dental care to 1 of 1 resident (Resident #68) reviewed for timely dental care. This deficient practice created the potential for harm if the resident's nutritional status was altered or if she developed an infection related to dental damage. Findings include: Resident #68 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including cellulitis of the left lower leg, diabetes, COPD, lack of coordination, delusional disorders, depression, and anxiety. A quarterly MDS Assessment, dated 7/24/25, documented Resident #68 was cognitively impaired. Resident #68's care plan, initiated 11/13/24, and updated on 3/12/25 alerted staff Resident #68 did not have teeth, would not wear dentures, and could be at nutritional risk related to additional diagnoses of diabetes and COPD. Resident #68's care plan, initiated on 7/1/25, documented Resident #68 was edentulous (toothless or someone who is missing teeth) and complaining of lower gum pain. The care plan further directed staff to monitor for signs and symptoms of oral and dental problems needing attention including pain (gums, toothache, palate), . teeth missing, loose, broken, eroded, or decayed. A Change of Condition (CIC) progress note, dated 8/17/25, documented Resident #68 stated her mouth was hurting from a broken tooth and wanted to have something put on it. During inspection, it was noted Resident #68 had few teeth remaining in her lower front jaw and her tooth appeared to be broken off at the gum line. The area [around the tooth was] red and some bleeding [was] noted. The CIC progress note further documented Resident #68 should have Orajel 3 times per day for pain relief and recommended a follow-up with a dentist. An alert charting note, dated 8/17/25, directed staff to monitor Resident #68's broken tooth in the left lower jaw for signs and symptoms of infection to include pain, drainage, temperature or trouble eating for every shift. On 9/9/25 at 3:46 PM, Resident #68's representative stated he was concerned the facility had not been able to make a dental appointment for his mother as she only had 4 teeth on her lower jaw and one of her teeth had recently broken. A review of Resident #68's record did not document the facility attempted to set up a dental appointment prior to 9/10/25. On 9/11/25 at 9:51 AM, the DON stated Resident #68 recently started complaining of oral discomfort and did not provide a reason why a dental appointment had not been scheduled in July 2025 or August 2025.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined the facility failed to ensure resident's received hydration beverages during dining. This was true for 1 of 18 residents (Resident #3) observed coughing without a hydration beverage. This deficient practice created the potential for harm if hydration was not provided during meals. Findings include: Resident #3 was readmitted on [DATE], with multiple diagnoses including atrial fibrillation, coronary artery disease, hypertension, renal insufficiency, and hyperlipidemia. On 9/8/25 at 12:00 PM, it was observed in the second-floor dining room Resident #3 was seated at a table with Resident #85. Resident #3 did not have beverages at her dining area; whereas Resident #85 had two beverages in front of him. On 9/8/25 at 12:30 PM, Resident #3 was observed coughing at her table while eating her lunch. The Dietary Manager (DM) asked Resident #3 if she was okay, she requested ice tea, which after drinking, her coughing stopped. On 9/8/25 at 12:45 PM, the DM stated beverages are provided whenever a resident asks for them. He stated, the CNA's are responsible for handing out the beverages. The DM could not explain why there were multiple resident's without drinks, including Resident #3 when Resident #85 had beverages.		

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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, record review, staff interview, and the Food and Drug Administration (FDA) Food Code, it was determined the facility failed to ensure: a) ice machines and pans were cleaned and sanitized, b) appropriate glove use was followed by employees, and c) stored food and spices were not expired. This was true for 98 resident's who consumed food stored and prepared by the facility. This deficient practice placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: 1. The FDA Food Code Section 2-301.14 When to Wash documented food employees shall clean their hands immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and before donning gloves to initiate a task that involves working with food. On 9/11/25 between 11:38 AM and 12:20 PM, multiple observations were made during tray line when Dietary Aide #1 did not wash his hands between changing tasks of using his bare hands to serve resident food with ladles and then donning gloves to directly touch resident food to cut up for dietary restrictions, then doffing gloves to continue serving resident food with ladles. There was no hand hygiene performed between glove use and change of tasks. On 9/11/25 at 12:25 PM, the DM stated since Dietary Aide #1 had not left his workstation and was serving food consistently, less than 4 hours, handwashing between glove use was not needed. 2. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, documented marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. On 9/11/25 at 4:00 PM, it was observed in the Assisted Living Kitchen, which prepares the food for the [Facility], multiple items were expired: Supreme Salad Mix: Expired 11/7/20 Baking Soda: Expired 6/25 Moldy Tomatillos: Dated 9/1/25 (Use by date not identified) Moldy Yams: No date On 9/11/25 at 4:17 PM, the DM stated the main kitchen is run by a different facility and they should have identified the expired food items and thrown them away. 3. The FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils, documented surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned. On 9/8/25 at 11:10 AM, it was observed in the second-floor meal kitchen the ice machine had a black residue running down the right interior side of the ice machine. On 9/8/25 at 11:14 AM, the DM stated the ice machine was last cleaned on 8/25/25 and it is cleaned monthly. He was not sure why there was black residue in the ice machine. 4. The FDA Food Code Section 4-602.12 Cooking and Baking Equipment documented food-contact surfaces of cooking equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use. On 9/11/25 at 4:35 PM, it was observed in the Assisted Living Kitchen, 1. A cooking skillet with black residue encrusted on the interior of the skillet, and 2. A cooking skillet with teflon coating which had multiple scratches on the cooking area of the skillet. On 9/11/25 at 4:40 pm, the DM stated the cooking skillet with the black residue was visibly dirty, and the skillet with the scratches should have been thrown away. He was not sure why the manager of the Assisted Living Kitchen had not cleaned and/or thrown away the dirty and scratched skillets.		

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Division of Occupational Licenses database, facility personnel records, staffing schedules, and staff interviews it was determined the facility failed to ensure all registered nurses were working with a valid nursing license. This deficient practice had the potential to significantly harm residents if licensed nurses did not have the knowledge, competencies, and skill sets to provide care and respond to resident's needs. Findings include: On [DATE], a review of the Division of Occupational Licenses database documented RN #1's professional license had expired on [DATE]. On [DATE], a review of the nurse staffing schedule documented RN #1 worked at the facility, performing licensed nursing duties on the following dates: [DATE]/[DATE]/[DATE]/[DATE]/25 On [DATE] at 1:00 PM, the DON stated he found out RN #1's license was expired on [DATE] and reassigned her to do a 1:1 observation on a resident. The DON confirmed RN #1 worked 6 shifts before re-assigning her to the 1:1 observation.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of the Left Ventricular Assist Device (LVAD) Management Manual, the facility failed to implement appropriate infection prevention and control practices during medication administration, medication storage, and a sterile dressing change for 2 of 2 residents (#2 and #50) reviewed for infection control. This failure created the potential for cross-contamination, infection, and life-threatening complications. Findings include: 1.On 9/10/25 at 8:25 AM, during a medication administration observation, RN #3 was preparing medications when a tablet fell from the medication cup onto the top surface of the medication cart. RN #3 donned a glove, picked up the tablet from the cart surface, and returned it to the medication cup. She continued preparing and administering medications to Resident #50.On 9/10/25 at 8:45 AM, RN #3 stated that cross-contamination may have occurred when the tablet contacted the cart surface. She reported sanitizing the cart at the beginning of her shift but did not sanitize it immediately prior to preparing medications. 2.On 9/10/25 at 9:44 AM, during a medication cart audit, an open Rock Star energy drink and an open bag of pretzels were found in the third drawer of the medication cart located in the 220 hall. On 9/10/25 at 9:46 AM, LPN #3 stated that food should not be stored in the medication cart and was unsure who had placed the items there.On 9/10/25 at 10:09 AM, the DON stated that the facility's expectation is that no food or beverages are to be stored in medication carts.3.Resident #2 was readmitted to the facility on [DATE], with multiple diagnoses including end stage heart failure, cirrhosis of the liver, and immunodeficiency. Resident #2's care plan, initiated 6/30/25, directed staff to don gown and gloves for high-contact personal care activities due to the presence of a LVAD.The LVAD Management Manual (undated) documented that dressing changes are considered sterile procedures and require the use of a mask, surgical cap, and a sterile field for dressing materials.On 9/11/25 at 11:54 AM, LPN #4 entered Resident #2's room, retrieved the dressing package from his dresser and placed it directly on the bed without a barrier. She placed her gloves on top of the packaging and proceeded to don her gown. LPN #4 then opened the dressing materials. No sterile field was established.LPN #4 assisted Resident #2 with donning a surgical mask and then placed her own mask. She removed the soiled dressing, discarded it along with her gloves, performed hand hygiene, and continued the dressing change using clean gloves. When asked whether the procedure was sterile or clean, LPN #4 stated it was a clean procedure.On 9/11/25 at 12:15 PM, the DON stated that LPN #4 should have placed a barrier between the bed and the dressing materials and confirmed that the procedure should have been performed using sterile technique.		