STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure 1 of 3 residents (Resident 1) reviewed for Pressure Ulcer/Pressure Injury (PU/PI) was provided with the necessary treatment and services consistent with professional standards of practice to promote healing and/or prevent worsening. The failure to establish a routine monitoring procedure necessary when using an air mattress (a specialized bed surface with inflatable air chambers that inflate and deflate in cycles to continuously redistribute a person's weight, preventing pressure sores [bedsores] by improving circulation and relieving sustained pressure on vulnerable areas like hips, shoulders, and heels, especially for bedridden individuals) and ascertain its proper functioning placed residents at risk for deterioration in skin condition, pain, and a diminished quality of life. Findings included.<Facility Policy>The facility policy titled, Pressure Injury Prevention and Management, revised 11/2024, showed the facility was committed to provide treatment and services to heal PU/PI and to prevent avoidable PU/PI, unless clinically unavoidable. The policy showed, after completing a thorough assessment/evaluation, evidence-based interventions for PU/PI management and prevention would be implemented for all residents who were assessed at risk or who had a PU/PI present. The policy showed the facility would provide basic or routine care interventions including pressure redistribution measures to promote healing. <Resident 1>According to the 11/17/2025 Admission/readmission Assessment, Resident 1 had clear speech, memory impairment, and had multiple medical conditions including heart disease, respiratory failure, systemic infections, unstable blood sugar levels, and bilateral leg amputations. The assessment showed Resident 1 had two Stage 4 PU (the most severe type of PU/PI, involving full-thickness tissue loss where the wound extends down to exposed bone, muscle, tendon, or ligament) on their buttocks area. The assessment showed Resident 1 was confined in bed; with limited mobility to move or change their position independently for pressure relief. Review of Resident 1's 11/17/2025 baseline Care Plan (CP) showed the resident had actual skin impairment. A CP intervention listed to address this nursing problem was the use of a specialty mattress to maintain and/or prevent further skin breakdown. The 11/17/2025 Safety Device Assessment showed Resident 1 was assessed for the safe use of an air mattress as a pressure relieving measure. The assessment showed the risk and benefits of its use was discussed with the resident and their representative. On 12/09/2025 at 8:32 AM, Resident 1's representative stated they observed the air mattress on Resident 1's bed was deflated and the resident appeared to be lying on the metal bars of the bed during their visit on 11/25/2025. The representative stated they called for assistance and the staff who came into the room did not even notice or acknowledge the air mattress was not on/working. The representative stated, when the wound nurse checked Resident 1's skin the following day on 11/26/2025, they observed the resident's whole back was red and was getting worse so the representative insisted to send Resident 1 out to the hospital for further evaluation and treatment. In an interview on 12/09/2025 at 2:19 PM, Staff C (Social Services Director) stated, on 11/25/2025, Resident 1's representative called them for assistance regarding the air mattress. Staff C confirmed the air mattress was unplugged when they entered Resident 1's room. In an interview on 12/09/2025 at 2:29 PM, Staff D (Certified Nursing Assistant) stated they were with Staff C during the incident on 11/25/2025 and confirmed the air mattress was unplugged when they entered Resident 1's room. Staff D stated they do not know the last time when Resident 1's air mattress was checked for proper functioning. Review of the November 2025 Treatment Administration Record showed there was no physician order in place directing nursing staff to monitor Resident 1's air mattress for proper function and setting until 11/26/2025; after the incident occurred. In a joint interview and record review on 12/23/2025 at 12:02 PM with Staff A (Administrator) and Staff B (Director of Nursing), Staff A stated the use of an air mattress was important for wound healing. Staff B stated the nursing staff was responsible for checking the air mattress every shift for proper function and setting. Both staff reviewed Resident 1's medical records. Staff B stated they could not determine when Resident 1's air mattress was checked last because there was no order to monitor the device prior to the incident on 11/25/2026. Staff B stated the order should have been, but was not, initiated on 11/17/2025; the day the air mattress was put in place according to the safety device assessment. REFERENCE: WAC 388-97-1060(3)(b)