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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, the facility failed to ensure residents were provided a homelike environment for 2 of 4 units (100 Unit and 200 East Unit) and 1 of 1 dining room. The failure to ensure resident rooms were free of wall scrapes, broken or missing window screens, and unpleasant stains, and ensure dining areas were free of clutter, placed residents at risk for a less than homelike environment and a diminished quality of life.Findings included.<Facility Policy>According to the facility's January 2026 Safe and Homelike Environment policy, the facility would provide a safe, clean, comfortable and homelike environment. A determination of homelike should include the resident's opinion of the living environment.<100 Unit>Observation of room [ROOM NUMBER] on 03/18/2026 at 10:16 AM showed significant wall gouges behind bed 2 where the head of the bed scraped the wall. Observation of room [ROOM NUMBER] on 03/18/2026 at 1:25 PM showed the flyscreen was missing from the right side of the window. There was nothing to prevent pests from entering the room if a resident wanted to open their window. The wall behind bed 1 had significant dark wall gouges where the head of the bed scraped the wall. Observation of room [ROOM NUMBER] on 03/19/2026 at 10:40 AM showed the flyscreen to the left side of the window was torn and frayed. This left a whole large enough for pests to enter the room if a resident wanted to open their window and was not homelike. In an interview and observation on 03/24/2026 at 1:12 PM Staff A (Administrator) observed the wall scrapes and missing/torn flyscreens on the 100 unit and stated the missing/torn screens did not prevent pests from entering if the window was open and was not homelike. Staff A stated the wall scrapes were not homelike and needed to be fixed. <200 East> In an observation and interview on 03/19/2026 at 10:07 AM, room [ROOM NUMBER] showed a white double closet with doors labeled A and B within Resident 69's view from their bed. On the closet door labeled B, there was a dark red vertical line approximately six inches long, with a dried drip at the bottom of the line. The closet door handle contained dried smears of dark red matter. Resident 69 stated their previous roommate had blood and feces in their shared room, and there was still blood on the roommate's closet door. Resident 69 stated they thought it was gross, and they were concerned someone was going to touch the blood on the closet door handle. Resident 69 stated they reported this to various managers, social workers, and nurses a couple of weeks earlier and no one took care of it. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/23/2026 at 8:59 AM showed the same dark red vertical line on the closet door and smears on the closet door handle. In an interview on 03/24/2026 at 10:58 AM, Staff G (Resident Care Manager) observed the same dark red vertical line on the closet door and smears on the closet door handle. Staff G stated it was important to clean the stains on the closet door because Resident 69 expressed they were not happy about it. <Dining Room> Observation of facility's dining room on 03/20/2026 at 11:53 AM showed the facility's dining room was laid out in an offset shape. In addition to two resident tables set up with green tablecloths, the narrower half of the dining room was used to store facility equipment, and remodeling supplies including: four tables, one stacked upside down on top of another; a first-aid mannequin with a paper wound attached to the left lower leg lying across the other two tables; a treatment supply cart, two mechanical lifts, a palate with remodeling supplies and a palate jack, an old steam table with several iced tea dispensers and coffee urns placed on top, two fall mats and foam spacers used to secure resident mattresses on the bedframe, some bagged items, a milk crate on top of the palate with vases inside, and three other palates with remodeling supplies. Behind the steam table were two long wide areas of mismatched paint consistent with cabinetry removal. In an interview and observation on 03/24/2026 at 1:14 PM Staff A stated the ad hoc storage in the dining room did not contribute to a homelike environment. Staff A stated the facility invested a lot of resources into improving the living environment for residents but there was still work to do. REFERENCE: WAC 388-97 -0880, -2040.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to properly prepare 1 of 1 resident (Resident 106) reviewed for discharge and complete the appropriate transfer notifications for 7 of 7 residents (Residents 104, 24, 8, 13, 2, 69, & 85) reviewed for hospitalization. The failure to offer bed holds (Residents 8, 2, & 85), provide a written transfer notice (Residents 2 & 85), provide report to receiving facilities (Residents 104, 8, 24, 13, 2, 69, & 85) and prepare resident for discharge (Resident 106) placed residents at risk for a disruption in their continuity of care, an undesired room change upon readmission, not having the opportunity to make informed decisions about their transfer/discharge rights, and inappropriate transfers.Findings included .<Policy>According to the facility policy titled, Bed Hold, dated 01/2026, the facility would inform Residents and/or resident representative of the facility's bed hold policy prior to transfer/discharge. The facility would provide a written transfer notification at the time of transfer/discharge and maintain a signed and dated copy in the resident's record. The Bed Hold policy showed it applies to all residents regardless of payment source.According to the facility policy titled, Transfer and Discharge (including AMA), dated 01/2026, showed transfers must occur in a manner that ensures resident health, safety, and continuity of care needs are met. The facility would evaluate resident needs, communicate, and coordinate the transfer appropriately. <Resident 106> According to the 12/27/2025 admission Minimum Data Set (MDS -an assessment tool) Resident 106 admitted to the facility on [DATE]. The MDS showed Resident 106 had diagnoses of respiratory disease, heart failure, cancer, and kidney failure. Review of Resident 106's health records showed a nurse progress note the resident discharged on 12/28/2025 Against Medical Advice (AMA). Resident 106's records showed no documentation of the provider notified, no documentation of a discharge summary offered or provided, no documentation of arrangements for medications, oxygen therapy, or home health care services offered or provided. Resident 106's records showed no documentation of a follow up appointment scheduled with the residents' primary care provider for continuation of care. In an interview and record review on 03/24/2026 at 9:23 AM Staff E (Resident Care Manager -RCM) reviewed Resident 106's records and stated there was no documentation of the provider notified of the AMA discharge, no documentation prescriptions/medications, or oxygen were offered or arranged for Resident 106. Staff E reviewed Resident 106's records and stated there was no documentation of the resident's Primary Care Provider (PCP) follow up appointment scheduled or home health therapy offered and/or arranged but should be. Staff E stated it was important to notify the facility provider of AMA discharges, offer and/or arrange medications, oxygen, home health therapy, and arrange a follow up appointment with the resident's PCP to ensure the residents safety and prevent rehospitalization. <Resident 104> According to the 03/01/2026 Discharge Return Anticipated MDS, Resident 104 admitted to the facility on [DATE]. The MDS showed Resident 104 discharged to the hospital on [DATE]. Review of Resident 104's health records showed no documentation of a report to the receiving hospital for the 03/01/2026 transfer. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 03/23/2026 at 10:44 AM Staff B (Director of Nursing) stated they expected staff to provide a written transfer notification at time of transfer, review the bed hold policy with the resident, and call the receiving facility to give nurse-to-nurse report on the resident's condition. Staff B reviewed Resident 104's records and stated there was no documentation of report to the receiving facility provided for the 03/01/2026 transfer. Staff B stated it was important to give report to the receiving facility for continuity of care. <Resident 8> According to the 03/10/2026 Quarterly MDS, Resident 8 admitted to the facility on [DATE]. The MDS showed Resident 8 had falls with injury since admission to the facility. Review of Resident 8's records showed a hospital transfer on 06/24/2025. Resident 8's records showed no documentation of report to the receiving facility or bed hold offered for the 06/24/2025 transfer. In an interview and record review on 03/23/2026 at 10:44 AM Staff B reviewed Resident 8's records and stated there was no documentation of nurse-to-nurse report to the receiving facility or bed hold offered for the 06/24/2025 transfer but should be. <Resident 24> According to the 01/14/2026 Quarterly MDS Resident 24 admitted to the facility on [DATE]. The MDS showed Resident 24 had no memory impairment. Review of Resident 24's records showed they were transferred to the hospital on [DATE], 11/07/2025, and 11/13/2025. Resident 24's records showed no documentation of report to the receiving facilities for the 08/05/2025, 11/07/2025, and 11/13/2025 transfers. In an interview and record review on 03/23/2026 at 10:44 AM Staff B reviewed Resident 24's records and stated there was no documentation of a nurse-to-nurse report to the receiving facilities for the 08/05/2025, 11/07/2025, and 11/13/2025 transfers but should be. <Resident 13> According to the 01/06/2026 Annual MDS Resident 13 admitted to the facility on [DATE]. The MDS showed Resident 13 had no memory impairment. Review of Resident 13's records showed 02/04/2025, 03/22/2025, 09/29/2025, 10/28/2025, and 12/27/2025 transfers to the hospital. Resident 13's records showed no report to the receiving hospitals was provided. In an interview and record review on 03/23/2026 at 10:44 AM Staff B reviewed Resident 13's records and stated there was no documentation of report to the receiving facilities for the 02/04/2025, 03/22/2025, 09/29/2025, 10/28/2025, and 12/27/2025 transfers. <Resident 2> According to the 12/26/2025 Significant Change MDS, Resident 2 admitted to the facility on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS showed Resident 2 had memory impairments and medically complex conditions. Review of Resident 2's records showed a hospital transfer on 12/19/2025. Resident 2's records showed no documentation of a nurse-to-nurse report to the receiving hospital for the transfer, no documentation of a bed hold offered, and no documentation of a written transfer notification provided to Resident 2 or their representative. In an interview and record review on 03/24/2026 at 10:20 AM, Staff G (RCM) reviewed Resident 2's records and stated there was no documentation of a nurse-to-nurse report provided to the receiving hospital, no documentation of a bed hold offered, and no documentation of a written transfer notification provided for the 12/19/2025 hospital transfer. Staff G stated sometimes nurses forgot the required documentation in an emergency, and it was a work in progress. <Resident 69> According to the 02/12/2026 Quarterly MDS, Resident 69 admitted to the facility on [DATE]. The MDS showed Resident 69 had no memory impairments. Review of Resident 69's records showed a hospital transfer on 11/10/2025. Resident 69's records showed no documentation of a nurse-to-nurse report to the receiving hospital for the 11/10/2025 transfer. In an interview and record review on 03/24/2026 at 10:20 AM, Staff G reviewed Resident 69's records and stated there was no documentation of a nurse-to-nurse report provided to the receiving hospital. Staff G stated nurses should document their attempts to reach hospital staff, and document to whom a report was given, but they did not. <Resident 85> According to the 03/09/2026 admission MDS, Resident 85 admitted to the facility on [DATE]. The MDS showed Resident 85 had diagnoses of traumatic spinal cord dysfunction and renal insufficiency/failure. Review of Resident 85's health record showed they were transferred out of facility to a hospital on [DATE], 01/04/2026, 02/26/2026, and 03/19/2026. Resident 85's health record showed no documentation to support a bed hold offered to the resident and/or resident representative at the time of transfer on 12/19/2025. Resident 85's records showed no documentation of report to the receiving facilities for the 12/19/2025, 01/04/2026, 02/26/2026, and 03/19/2026 transfers. In an interview and record review on 03/23/2026 at 1:37 PM Staff B reviewed Resident 85's medical record and stated there was no documentation a bed hold was offered to the resident or resident representative at time of transfer on 12/19/2025. Staff B reviewed Resident 85's records and stated there was no documentation of report to the receiving facilities for the 12/19/2025, 01/04/2026, 02/26/2026, and 03/19/2026 transfers but should be. Reference: WAC 388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), -0080, -0140(1)(a)-(c)(i)-(iii).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the mental health conditions for 1 of 6 residents (Resident 10) and PASRR level 2 referrals were coordinated timely for 2 of 6 residents (Residents 11 & 8) reviewed for PASRRs. This failure placed residents at risk of inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs.Findings included.<Policy>According to the facility policy titled, Resident Assessment-Coordination with PASRR Program, dated 01/2026, the facility would coordinate assessments with the PASRR program to ensure individuals with mental disorder, intellectual disability or a related condition received the care and services in the most integrated setting appropriate to their needs. The policy showed PASRR 1 would be completed prior to admission and a positive PASRR 1 necessitated a PASRR 2 evaluation prior to admission to the facility. The policy showed social services would keep track of each resident's PASRR screening status and refer to appropriate authority. The policy showed any resident with behavioral, psychiatric, or mood related symptoms suggesting the presence of mental disorder would be referred promptly for a PASRR 2. <Resident 10> According to the 02/17/2026 admission Minimum Data Set (MDS - an assessment tool) Resident 10 had a traumatic brain injury and a cognitive communication deficit. The MDS showed Resident 10 took an antidepressant medication. Review of the 01/23/2026 Hospital History and Physical report showed Resident 10 had a history of Alcohol Use Disorder ([NAME]). Review of the 01/26/2026 Level 1 PASRR screening showed Resident 10 was flagged with Serious Mental Illness (SMI) indicators of mood and anxiety disorders. This Level 1 screening did not capture Resident 10's [NAME] status. Record review showed on 02/28/2026 the facility submitted a corrected Level 1 PASRR for Resident 10 that now included an SMI indicator of Substance Use Disorder (SUD). In an interview on 03/24/2026 at 1:38 PM, Staff C (Social Services Director) stated the nursing department was responsible for making sure residents' PASRR screenings were updated when something changed or if errors were identified with the Level 1 PASRR screening. Staff C stated reviewing PASRRs prior to admission was handled by the Admissions department. In an interview on 03/24/2026 at 1:48 PM, Staff Z (Admissions Director) stated they verified the accuracy of Level 1 PASRR screening prior to admit by ensuring all the boxes were complete and a referral for Level 2 services was indicated as needed. Staff Z stated they did not look at other admissions documentation from the receiving hospital to ensure the information provided was accurate, as required. <Resident 11> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/26/2026 Annual MDS Resident 11 admitted to the facility on [DATE]. The MDS showed Resident 11 had diagnoses of anxiety, depression, and post-traumatic stress disorder. Review of Resident 11's records showed a 03/26/2025 PASRR 1 with referral for a PASRR 2 required. Resident 11's records showed no PASRR 2 was completed. <Resident 8> According to the 03/10/2026 Quarterly MDS Resident 8 admitted to the facility on [DATE]. The MDS showed Resident 8 had diagnoses of non-Alzheimer's dementia, anxiety, depression and post-traumatic stress disorder. Review of Resident 8's records showed a 07/18/2025 PASRR 1 with referral for a PASRR 2 required. Resident 8's records showed no PASRR 2 was completed. In an interview and record review on 03/24/2026 at 1:45 PM Staff C reviewed Resident 11 and 8's records and stated PASRR 2 was not completed. Staff C stated timely follow up on the PASRR 2 referrals was not done so they were missed. Staff C stated it was important to ensure PASRR 2 was completed to make sure the residents received optimal individualized mental health care. Reference: WAC 388-97-1915(1)(2)(a-c).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure accurate and complete pre/post Hemodialysis (HD- mechanical way of eliminating waste from the body when the kidneys no longer functioned) for 3 of 3 residents (Residents 86, 24, & 13) reviewed for Dialysis. This failure placed the residents at risk for unintended health consequences and decreased quality of life.Findings included.<Policy>Review of the facility's 08/01/2025 HD policy showed that the facility would ensure that each resident received care and services for the provision of HD including ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatment. The facility's 08/01/2025 HD policy states that residents would not receive blood pressures on the arm that a HD device is located. <Resident 86> Review of the 02/20/2026 admission Minimum Data Set (MDS – an assessment tool) Resident 86 admitted to the facility on [DATE] with diagnoses of End Stage Renal Disease (ESRD -Permanent impairment of kidney function often requiring transplant or HD), dependence on HD and a history of kidney transplant failure. Resident 86 was on HD during the assessment period. Review of Resident 86's records showed a physician order to complete HD pre/post assessments on their HD treatment days Monday, Wednesday, and Friday. The physician orders showed Resident 86 had an HD fistula (an HD access device) present to the left arm, right arm, and right thigh. Review of Resident 86's 02/15/2026 HD Care Plan (CP) showed not to take blood pressure on limbs with a HD access device. The CP did not state where Resident 86's HD access devices were located. Review of Resident 86's records titled NSG-Dialysis Review Pre/Post (an assessment tool used by the facility to document pre and post HD assessments) showed HD assessments on the following dates: 02/16/2026, 02/18/2026, 02/20/2026, 02/21/2026, 02/23/2026, 02/25/2026, 02/27/2026, 03/04/2026 were inaccurate and/or incomplete. In an interview on 03/19/2026 at 11:50 AM Resident 86 stated that staff check their blood pressure on either arm. In an observation and interview on 03/20/2026 at 11:08 AM Staff F (Licensed Practical Nurse) completed the pre-dialysis assessment for Resident 86 checking their blood pressure on the resident's right arm. Staff F stated that HD assessments need to be completed before and after HD and included checking Resident 86's fistula for function and taking vital signs. In an interview on 03/24/2026 at 9:45 AM Staff E (Resident Care Manager) stated HD assessments for Resident 86 should include checking the vital signs, checking the fistula for function, and checking for signs of bleeding when returning from HD. Staff E stated blood pressure should not be taken on the limb with a HD access device as it could cause complications needing medical intervention. Staff E stated that staff should know where to check Resident 86's blood pressure as it would be on their CP to inform staff. Staff E reviewed Resident 86's health records and stated that the information was not on the CP and that the vitals record showed that Resident 86's blood pressure was checked on either arm all but three times since admission. Staff E reviewed the HD assessments for Resident 86 and stated they were inaccurate and missing information and did not meet expectations. Staff E stated it was important to complete pre/post HD assessments for Resident 86 to monitor for low blood pressure, signs of bleeding, and sign of infection. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/24/2026 at 11:49 AM Staff B (Director of Nursing) stated that Resident 86's pre/post HD assessments should have been filled out completely, accurately, and timely but were not. <Resident 24> According to the 01/14/2026 Quarterly MDS Resident 24 admitted to the facility on [DATE]. The MDS showed Resident 24 had a diagnosis of ESRD and required HD treatment. Review of Resident 24's 01/01/2026, 01/02/2026, 01/05/2026, 01/07/2026, 01/09/2026 x2, 01/12/2026, 01/14/2026, 01/16/2026, 01/17/2026, 01/19/2026, 01/21/2026, 01/26/2026, 01/28/2026 x2, 01/31/2026, 02/02/2026 x2, 02/04/2026, 02/06/2026, 02/09/2026, 02/11/2026, 02/13/2026 x2, 02/16/2026, 02/18/2026, 02/20/2026, 02/23/2026, 02/25/2026, 02/27/2026 x2, 03/02/2026, 03/04/2026, 03/06/2026, 03/09/2026, 03/09/2026, 03/11/2026, 03/13/2026, 03/16/2026, 03/18/2026, and 03/20/2026 pre/post HD assessments showed the assessments were incomplete and inaccurate. Resident 24's pre/post HD assessments showed the HD site was not assessed, and historical vital signs and weights were used and not checked pre/post HD treatment. <Resident 13> According to the 01/06/2026 Annual MDS Resident 13 admitted to the facility on [DATE]. The MDS showed Resident 13 had a diagnosis of ESRD and required HD treatment. Review of Resident 13's 01/01/2026 x2, 01/03/2026, 01/04/2026, 01/06/2026, 01/08/2026 x2, 01/10/2026 x2, 01/13/2026, 01/15/2026 x2, 01/20/2026, 01/22/2026, 01/27/2026, 01/31/2026, 02/03/2026, 02/05/2026, 02/07/2026, 02/10/2026, 02/12/2026, 02/14/2026, 02/17/2026, 02/19/2026, 02/21/2026, 02/24/2026, 02/26/2026, 02/28/2026, 03/04/2026, 03/05/2026, 03/07/2026, 03/10/2026, 03/12/2026, 03/14/2026, 03/17/2026, 03/19/2026 x2, and 03/21/2026 pre/post HD assessments showed the assessments were incomplete and inaccurate. Resident 13's pre/post HD assessments showed the HD site was not assessed, and historical vital signs and weights were used and not checked pre/post HD treatment. In an interview and record review on 03/23/2026 at 10:44 AM Staff B reviewed Resident 24 and 13's HD pre/post assessments and stated they were incomplete and inaccurate. Staff B stated they expected staff to complete the pre/post HD assessments and obtain current vitals and weights with each assessment. Staff B stated they expected staff to thoroughly assess the residents HD sites for function, identify the location, bleeding, dressings, and for any signs of infection or complications. Refer to F656 Develop/Implement Comprehensive Care Plan. Reference: WAC 388-97-1900(1), (6)(a-c).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure proper storage and labeling of medications for 2 of 4 medication rooms (West I and [NAME] II units), 2 of 4 medication carts (Central Medication Cart and [NAME] I Unit Medication Cart), and 1 of 4 treatment carts (West II Treatment Cart) reviewed for medication storage. This failure placed residents at risk for receiving incorrect medications, ineffective treatment, accidental ingestion of medication, and a diminished quality of life.Findings included.<Facility Policy>According to the facility's 01/2026 Medication Storage policy, the facility would ensure all medications were stored in locked compartments or rooms. The policy showed that medications with missing labels would be destroyed.<West I Medication Cart> Observation on 03/19/2026 at 1:20 PM of the [NAME] I unit medication cart showed two loose pills in the top drawer. Observation on 03/23/2026 at 9:24 AM of the [NAME] I medication cart showed the lower right drawer was unlocked and unattended with no staff supervising the cart. The drawer of the cart contained a bottle of medicated laxative powder, packs of syringes, a pack of smoking cessation patches, a tube of medicated pain-relieving cream, packs of testing kit, and a small pair of scissors. In an interview on 03/23/2026 at 9:57 AM, Staff R (Registered Nurse - RN) stated the medication cart should be locked so that no one can have access to it. Staff R stated it was important to protect residents from having access to medications and risk for ingesting inappropriate medications. <West I Medication Storage Room> Observation on 03/19/2026 at 1:52 PM of the [NAME] I unit medication storage room showed an open bottle of eye drops that did not indicate which resident they belonged to and an open bottle of pills that did not indicate which resident they belonged to. In an interview on 03/19/2026 at 1:39 PM Staff Q (Resident Care Manager - RCM) stated the medications should be labeled with the resident's name and date of opening. Staff Q stated it is important for resident safety. <West II Medication Storage Room> Observation on 03/20/2026 at 9:18 AM of the [NAME] II medication storage room showed a tube of pain-relieving cream that did not indicate a resident name, pain patches that did not indicate a resident name, and a box of smoking cessation gum without a resident name. In an interview on 03/20/2026 at 9:18 AM, Staff E (RCM) stated the opened medications should be separated from the unopened medications to distinguish them and remind staff of medication expiration date. In an interview on 03/23/2026 at 1:11 PM, Staff B (Director of Nursing) stated they expected the nurses to lock the medication cart before they leave it unattended. Staff B stated medications used in the medication storage room should be labeled with an open date, a resident name and room number (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER: Valley View Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4430 Talbot Road South, Renton, WA 98055	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to ensure safety. <Central Medication Cart> Observation on 03/19/2026 at 9:27 AM showed the central medication cart unlocked and unattended with no staff nearby monitoring. In an interview on 03/19/2026 at 9:30 AM Staff P (RN) came out of room [ROOM NUMBER] and stated they were assigned to the central medication cart but forgot to lock the cart before leaving it unattended. Staff P stated they should lock the medication cart before leaving it unattended for resident safety. In an interview on 03/23/2026 at 1:18 PM Staff B stated they expected nurses to lock medication and treatment carts before walking away. Staff B stated it was important to lock the medication and treatment carts to ensure resident safety. <West II Treatment Cart> Observation on the [NAME] II unit on 03/20/2026 at 10:46 AM showed the treatment cart was unlocked. The key was in the open lock, and no licensed staff were near the cart. The top drawer of the cart contained two tubes of medicated honey used for wound healing, two different pain-relieving creams, a bottle of medicated shampoo, two containers of medicated wound packing material, a small pair of scissors, and a box of medicated wipes. The second drawer of the treatment cart contained a bottle of medicated shampoo, antifungal creams, and antimicrobial wound gel, and a tube of medicated honey used for wound healing. The third drawer contained two bottles of medicated shampoo and two tubes of pain-relieving gel. The fourth drawer contained two types of antiseptic solution, a box of wound cleansers, and a canister of powerful surface cleaning wipes. In an interview on 03/20/2026 at 10:51 PM, Staff F (Licensed Practical Nurse) stated the treatment cart should be locked. Staff F stated there were treatments and supplies that residents should not have access to. REFERENCE: WAC 388-97-1300(2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to: ensure staff used appropriate Hand Hygiene (HH) during resident care for 3 residents (Resident 85, 110, & 6) who were observed for care; ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear, and gowns used to prevent exposure to infectious materials) for 1 (Resident 85) and 1 supplemental resident (Resident 96) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms); and ensure staff prevented clean linens from coming into contact with soiled surfaces. These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases.Findings included .<Facility Policies>According to the facility's Hand Hygiene policy, revised 01/2026, all staff would perform proper HH procedures to prevent the spread of infection. Staff would perform HH after handling items contaminated with body fluids, secretions, or excretions, and during resident care when moving from a contaminated body site to a clean body site.According to the facility's Enhanced Barrier Precautions policy, revised 01/2026, staff would use a gown and gloves during high-contact resident care activities for residents with an order for EBP.According to the facility's Infection Prevention and Control Program policy, revised 12/23/2025, laundry and direct care staff would handle, store, process, and transport linens to prevent the spread of infection. <Hand Hygiene> <Resident 85> Observation on 03/19/2026 at 9:31 AM showed Staff T (Licensed Practical Nurse) and Staff U (Certified Nurse Assistant - CNA) providing ileostomy (a surgical opening in the abdomen allowing stool to pass through to an external pouch), suprapubic catheter (surgically placed tube below the belly button allowing urine to pass through to an external pouch), and incontinence care to Resident 85. Staff T was observed to use a single glove to perform care tasks. Staff T used a wet gauze and wiped Resident 85's ileostomy site. Without changing gloves and performing HH, Staff T took a new ileostomy pouch and secured it to the ileostomy opening. Wearing the same, soiled gloves, Staff T took clean gauze and secured it over Resident 85's suprapubic catheter. Staff T removed the old catheter bag and old tubing while wearing the same gloves, and grabbed a new catheter tube, a new catheter bag, and a pair of scissors. Staff T did not remove their soiled gloves and did not perform HH. While wearing the same gloves, Staff T cut the new catheter tubing in half, inserted it into the catheter, and secured it to Resident 85's leg. Staff T removed their soiled gloves and performed HH. Staff U assisted with changing Resident 85's brief. Staff U removed the soiled brief from Resident 85. While wearing the same gloves, Staff U opened Resident 85's drawer, grabbed a clean brief, and placed it on the resident. Staff U removed their gloves, performed HH and left the resident's room. In an interview on 03/19/2026 at 9:48 AM Staff T stated it was important to perform HH and to change gloves between care tasks to prevent the spread of infection. <Resident 110> Observation on 03/18/2026 at 1:03 PM showed Staff L (CNA) providing incontinence care to Resident 110. Staff L removed Resident 110's wet and soiled incontinence brief and used wipes to clean Resident 110's skin. While wearing the same gloves and without performing HH, Staff L applied a clean incontinence brief, adjusted Resident 110's clothing and bed linens, and adjusted the position of the bed using the bed controller. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/24/2026 at 9:23 AM showed Staff N (CNA) providing incontinence care to Resident 110. Staff N removed Resident 110's wet and soiled incontinence brief and used wipes to clean Resident 110's skin. While wearing the same gloves and without performing HH, Staff N placed clean bed linens underneath Resident 110, bagged up garbage, and waited for Staff O (Registered Nurse) to complete a wound treatment. While wearing the same gloves and without performing HH, Staff N applied a clean incontinence brief, dressed Resident 110 in a clean hospital gown and placed a sling for a mechanical lift underneath Resident 110. <Resident 6> Observation on 03/20/2026 at 8:38 AM showed Staff I (CNA) and Staff J (Restorative Aide) providing incontinence care to Resident 6. Staff I and Staff J wiped Resident 6's skin and without removing their gloves, Staff I took the resident's top sheet and placed it under the resident. Staff J removed their soiled gloves and put on new gloves without performing HH. Staff J removed Resident 6's urine-soaked bed linens, placed them in a bag, removed their gloves, and put on new gloves without performing HH. Staff J grabbed the package of incontinence wipes and wiped the mattress down while Staff I assisted Resident 6 to lie on their side. Staff J grabbed the door handle, went to the hallway and grabbed disinfecting wipes while wearing the same gloves used to handle the urine-soaked linens. Staff J removed disinfecting wipes from the container and wiped down Resident 6's mattress. Staff J removed their gloves and put on new gloves without performing HH. Staff J grabbed clean linens and made Resident 6's bed. Staff I wiped Resident 6 once more with incontinent wipes and placed a clean brief on the resident. Staff I removed their soiled gloves, took new gloves out of their shirt pocket and put them on without performing HH. Staff I and Staff J removed Resident 6's gown and placed a clean gown on the resident. Staff I and Staff J used wipes to wipe down Resident 6's underarms and face while wearing the same gloves. Staff I and Staff J removed the garbage and bag of soiled linen and performed HH upon exiting Resident 6's room. In an interview on 03/23/2026 at 11:05 AM, Staff D (Infection Preventionist) stated staff should perform HH after glove use and in between dirty to clean tasks. Staff D stated they expected staff to perform HH between glove use. <Enhanced Barrier Precautions> <Resident 85> Review of a 01/21/2026 Resident requires EBP. care plan showed Resident 85 required the use of EBPs by staff to reduce the risk of spreading infection. Observation on 03/23/2026 at 10:05 AM showed Staff Y (CNA) remove soiled linens from Resident 85's bed. Staff Y was wearing gloves but did not have a gown on. Staff Y took a clean wipe and wiped down Resident 85's mattress. Wearing the same, soiled gloves, Staff Y grabbed clean linens and made Resident 85's bed. Staff Y placed the soiled linens in a trash bag, removed their gloves and performed HH before leaving the room. Staff Y did not wear PPE as directed. In an interview on 03/24/2026 at 1:11 PM, Staff B (Director of Nursing) stated they expected staff to wear proper PPE, including a gown, when changing residents' bedding who were on EBP. <Resident 96> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 96's order summary showed a 10/29/2025 order for EBP. Review of a 10/31/2025 care plan for EBP showed Resident 96 required EBP due to an indwelling medical device. Resident 96's care plan instructed staff to wear a gown and gloves when providing high-contact care. Review of Resident 96's March 2026 medication administration record showed from 03/01/2026 - 03/24/2026 nurses signed the order twice daily that the resident was on EBP precautions. Observation on 03/18/2026 showed Resident 96 sitting in their wheelchair receiving enteral nutrition (a method of providing a nutritionally complete diet through a feeding tube surgically placed into the stomach). There was no sign posted outside the door to show Resident 96 was on EBP, or PPE supplies provided for staff at the entry to their room. In an interview on 03/20/2026 at 10:11 AM Staff S (CNA) stated residents on EBP had a sign outside their door that indicated the requirement for PPE. In an interview on 03/23/2026 at 10:30 AM Staff D stated Resident 96 should be on EBP due to their indwelling medical devices and enteral nutrition. Staff D inspected the room and stated that Resident 96 was not on EBP but should be. <Linen Handling> Observation on 03/20/2026 at 11:53 AM of the facility's laundry room showed Staff K (Laundry Staff) folding clean linens. Staff K was observed folding flat sheets and was not using the folding table. Staff K held the sheet out in front of them and as they folded, the flat sheet dragged across the laundry room floor and the tops of their shoes. Staff K proceeded to take the folded sheet and place it on the clean linen cart used to transport linens to the resident units. Similar observations were made when Staff K proceeded to fold an additional flat sheet, two fitted sheets, and two resident gowns. In an interview on 03/23/2026 at 11:09 AM, Staff D stated it was their expectation clean linens did not touch the floor and should only touch clean surfaces. REFERENCE: WAC 388-97-1320 (1)(a)(c), (3).

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure informed consents explaining the potential risks, benefits, and alternatives of the use of bed mobility rails, vaccines, and/or treatment at the facility were obtained from the resident or their representative prior to implementation for 1 of 2 residents reviewed for physical restraints (Resident 82), and 1 of 5 residents (Residents 2) reviewed for immunizations. In addition, the facility failed to ensure Resident 2 had the cognitive ability to understand the risks prior to signing informed consents. These failures placed residents and/or their representatives at risk of not being fully informed of the potential risks, benefits, and alternatives to treatments, including vaccines and mobility devices.Findings included .<Resident 82> According to the 03/05/2026 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 82 had moderately impaired cognition (memory and decision-making facility) and usually understood others in conversation. The MDS showed Resident 26 had diagnoses including heart failure and dementia and required no restraints or alarms. Review of Resident 82's 10/20/2025 Safety Device Assessment showed therapy recommended the use of grab bars to assist with bed mobility and transfers and promote independence. This assessment showed the grab bars would not be a restraint for Resident 82 but did not show why. This assessment showed the risks and benefits of the grab bars were not discussed with Resident 82 or their representative and did not explain why this was not discussed. Observation on 03/18/2026 at 10:22 AM showed quarter rails (grab bars) in place on Resident 82's bed. At this time Resident 82 was observed to not be able to speak to the specifics of their care. In an interview on 03/24/2026 at 10:54 AM, Staff B (Director of Nursing) reviewed the assessment and stated the risks and benefits of the grab bars should be but were not discussed with Resident 82. <Resident 2> According to the 11/07/2025 admission MDS, Resident 2 admitted to the facility on [DATE] with diagnoses including multiple fractures and developmental delay (a condition that could affect physical, cognitive, communication, social, or emotional skills). Resident 2's Brief Interview for Mental Status (a quick screening tool to assess cognitive function) indicated they had severe cognitive impairment. Review of a Capacity for Medical Decisions form, signed on 11/03/2025, showed a physician's professional opinion was Resident 2 was unable to comprehend the risks, benefits, and alternatives to medical decisions, and could not make medical decisions on their own behalf due to their developmental delay. The form showed that according to the Washington State Hierarchy of Medical Decision Makers, Resident 2 had two family representatives that were their legal decision makers. Review of Resident 2's January 2026 Medication Administration Record (MAR) showed staff administered a vaccine for pneumonia (an infection of the lungs) on 01/02/2026. Immunization documentation showed staff confirmed they provided education and obtained consent for the pneumonia vaccine on 01/02/2026. No documentation was found to show who received the education and who provided consent. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's March 2026 MAR showed staff administered a vaccine for Respiratory Syncytial Virus (RSV - a respiratory illness that typically caused mild cold-like symptoms but could lead to severe respiratory illness) on 03/05/2026. Immunization documentation showed staff confirmed they provided education and obtained consent for the vaccine on 03/05/2026. Review of Resident 2's progress notes showed staff attempted to contact Resident 2's representatives on 02/28/2026, 03/01/2026, and 03/02/2026 to obtain consent for the RSV vaccine, but were unsuccessful. A progress note dated 03/02/2026 showed Resident 2 gave consent for the RSV vaccine. Review of a Consent to admission and Treatment form, dated 12/22/2025, showed Resident 2 signed that they voluntarily consented to treatment, understood the risks, and agreed to the facility's terms. The form was also signed by a facility representative. Observation on 03/18/2026 at 12:02 PM showed two staff assisted Resident 2 to transfer from their wheelchair to their bed. Resident 2's bed was equipped with mobility bars on the right and left sides, near the head of the bed. Review of an Informed Consent for Use of Mobility (Grab/Enabler) Bar form, dated 12/23/2025, showed Resident 2 signed that they understood the risks and benefits of mobility bars and consented to their use. In an interview on 03/24/2026 at 1:41 PM, Staff X (Director of Rehab) stated they discussed the use of mobility bars with Resident 2's representative during a care conference on 11/21/2025. Staff X did not find documentation showing Resident 2's representative received education regarding risks and benefits of mobility bars or that they consented to their use. In an interview on 03/24/2026 at 1:03 PM, Staff B stated Resident 2's representative was their decision maker, and staff sometimes had difficulty contacting them by phone. Staff B stated Resident 2's representative previously made a statement that whatever facility staff thought Resident 2 needed would be fine if Resident 2 agreed; no documentation was provided. Staff B stated they expected staff to follow up with Resident 2's representative to obtain informed consent when consent was required. Reference: WAC 388-97-0260.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on Observation, Interview, and record review the facility failed to ensure that Care Plans (CP) were comprehensive and person-centered for 3 of 21 sample residents reviewed (Resident 86, 26, & 5) This failure placed residents at risk for unmet care needs, frustration, and negative health outcomes.Findings Included .<Facility Policy>According to the facility's 08/01/2025 Hemodialysis (HD) policy the facility would provide the necessary care and treatment to meet the special medical and nursing needs of the residents receiving hemodialysis. The policy showed residents would not receive blood pressures on the arm that a hemodialysis device was located. <Resident 86> Review of the 02/20/2026 admission Minimum Data Set (MDS – an assessment tool) Resident 86 admitted to the facility with diagnoses of End Stage Renal Disease (Permanent impairment of kidney function often requiring transplant or dialysis), Dependence on Renal Dialysis (mechanical way of eliminating waste from the body when the kidneys no longer functioned), and a history of kidney transplant failure. Resident 86 was on HD at the time of admission. Review of the 02/15/2026 HD CP for Resident 86 stated do not draw blood or take blood pressure on arm with graft (a HD device). The HD CP does not state where the grafts were for Resident 86. Review of Resident 86's Physician Orders showed 02/15/2026 orders for three HD devices, one in the left arm, one in the right arm, and one in the right thigh. In an interview on 03/19/2026 at 11:50 AM Resident 86 stated that staff took their blood pressure on either arm. In an observation on 03/20/2026 at 11:08 AM Staff F (Licensed Practical Nurse) completed the pre-HD assessment for Resident 86 and checked their blood pressure using their right arm. In an interview on 03/24/2026 at 10:11 AM Staff E (Resident Care Manager) stated that when caring for Resident 86 staff should take blood pressure on their left leg. Staff E stated staff should know where to take the blood pressure as it should be on the CP and the Kardex (a short form version of the CP used to communicate care needs to staff). Staff E reviewed the vitals report and CP for Resident 86 and found blood pressures were usually taken on either arm and the CP did not show where the HD devices were for Resident 86. Staff E stated that staff should not take a blood pressure on the same limb as a HD access device as it can cause complications with the device which may need medical intervention. In an interview on 03/24/2026 at 11:49 AM Staff B (Director of Nursing) stated that residents on HD should have blood pressures taken on the limb without a HD access device. Staff B stated that staff would know where the HD access devices were for Resident 86 by seeing it on the CP or Kardex. Staff B reviewed Resident 86's medical records and stated the CP does not communicate where HD access devices were. Staff B stated that Resident 86's CP does not meet expectations. <Resident 26> According to the 02/12/2026 admission MDS Resident 26 had impaired vision, intact cognition, and had a fall with no injury since admission. The MDS showed Resident 26 was frequently incontinent of bladder and always incontinent of bowel. The MDS showed Resident 26 took an anti-seizure (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. Record review showed Resident 26 had a 02/07/2026 physician's order to check the placement of fall mats on both sides of their bed when unattended. This order was discontinued on 03/12/2026. Observation on 03/18/2026 at 1:55 PM showed fall mats placed on both sides of Resident 26's bed while the resident lay in bed. According to a 03/12/2026 Interdisciplinary Team (a group of facility managers) progress note showed Resident 26 stopped trying to get out of bed independently and no longer required the fall mats. This note showed Resident 26's CP was updated to reflect this change. Review of Resident 26's risk for falls. CP showed this CP included a 03/18/2026 intervention for Resident 26 to have mats on both sides of their bed. Review of the Kardex (direct care instructions) as of 03/19/2026 showed for safety, Resident 26 needed mats on both sides of their bed. In an interview on 03/24/2026 at 11:01 AM, Staff B stated the mats were no longer required. Staff B stated the mats should be removed from the CP in order to make the CP comprehensive and accurate, and removed from the Kardex. <Resident 5> According to the 02/12/2026 admission MDS, Resident 5 was dependent on staff for Activities of Daily Living (personal hygiene, eating, bathing etc.) and moving in bed. The MDS showed Resident 5 received their nutrition through a feeding tube and received physical therapy, occupational therapy, and speech-language pathology therapy. In an interview on 03/18/2026 at 12:01 PM Resident 5 stated they preferred some therapists over others and stated they had to stop therapy early that day because they became short of breath. Review of Resident 5's comprehensive CP showed no CP developed describing what therapies Resident 5 required, the schedule or frequency of therapy services. Review of Resident 5's Kardex showed no information provided describing what therapies Resident 5 required, the schedule or frequency of therapy services, or if/when/how nurses' aides should prepare the resident for therapy. In an interview on 02/24/2026 at 10:44 AM Staff B stated CPs should reflect residents' care needs. Staff B stated CPs and Kardex should be comprehensive. Staff B reviewed Resident 5's CP and Kardex and stated there was no CP developed outlining Resident 5's therapy services. Staff B stated those details should be included on the CP. Refer to F698 Dialysis. REFERENCE: WAC 388-97-1020(1)(2)(a)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the following: Administration of bowel care protocol in accordance with physician orders, administration of medications within the parameters set by physician orders, and completion of treatments for devices and wounds per physician orders for 3 of 21 sample residents (Residents 9, 107, & 110). These failures placed residents at risk for medication errors, untreated pain, and poor health outcomes.Findings Included .<Facility Policy>According to the facility's January 2026 Care and Maintenance of Central Venous Catheter (CVC - flexible tube inserted into a large vein and threaded towards the heart) policy, the facility staff would change the dressings on central lines based on the type of dressing every seven to ten days.According to the facility's revised January 2026 Wound Treatment Management policy, wound treatments would be provided in accordance with physician orders, including the type of dressing and frequency of dressing changes. Dressing changes would be provided as needed if the dressing was dislodged, wet, soiled, or feces seeped underneath the dressing. <Administration of Bowel Care Protocol> <Resident 9> Review of the 02/16/2026 Annual Minimum Data Set (MDS – An assessment tool) for Resident 9 showed that they re-admitted to the facility on [DATE] with diagnoses of a progressive neurological disorder that affected movement, muscle weakness, and a seizure disorder. Review of Resident 9's order summary showed a 12/23/2023 physician order directing staff to administer a laxative medication if the resident did not have a bowel movement for three days. Review of Resident 9's February 2026 Activities of Daily Living (ADL) documentation showed they did not have a bowel movement from 02/25/2026 until 03/01/2026, four days later. Review of Resident 9's February 2026 and March 2026 Medication Administration Record (MAR) showed staff did not administer the laxative medication as ordered. Review of nursing notes for Resident 9 showed staff offered the laxative medication on 03/01/2026, the fourth day without a bowel movement. In an Interview on 03/18/2026 at 10:15 AM Resident 9 stated they had no concerns related to bowel care. In an interview on 03/24/2026 at 9:45 AM Staff E (Resident Care Manager - RCM) stated if a resident did not have a bowel movement for three days, staff should follow the provider ordered bowel protocol and administer the laxative medication. Staff E reviewed Resident 9's record and confirmed staff did not administer the laxative as ordered to Resident 9. In an interview on 03/24/2026 at 11:49 AM Staff B (Director of Nursing) stated staff should have offered the ordered laxative medication to Resident 9 to prevent potential medical complications from constipation, but staff did not. <Medications Administered Outside the Parameters> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER: Valley View Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 4430 Talbot Road South, Renton, WA 98055	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 9> Review of Resident 9's 02/16/2026 Annual MDS showed they re-admitted to the facility on [DATE] with diagnoses of a progressive neurological disorder that affected movement, muscle weakness, and a seizure disorder. The MDS showed Resident 9 had pain almost constantly. Review of Resident 9's physician orders showed they received a narcotic pain medication patch every seven days, and a non-narcotic pain medication every eight hours as needed for pain on a scale of one to five out of ten. In an Interview on 03/18/2026 at 10:10 AM Resident 9 stated that their pain was well controlled, though did occasionally use a non-narcotic pain medication as needed. The March 2026 MAR showed staff administered the non-narcotic pain medication to Resident 9 on the following days for pain levels above the ordered parameter: 03/01/2026 at 11:55 AM for a pain level of seven out of ten, 03/04/2026 at 2:30 PM for a pain level of seven out of ten, 03/11/2026 at 12:57 PM for a pain level of six out of ten, 03/14/2026 at 8:44 AM for a pain level of six out of ten, and 03/22/2026 at 11:23 AM for a pain level of seven out of ten. In an interview on 03/24/2026 at 11:49 AM Staff B stated staff should have followed the parameters of the physician orders and notified the physician if pain levels were above the ordered parameter to ensure Resident 9 had adequate pain control. <Completion of Treatments for Devices and Wounds> <Resident 107> Review of Resident 107's 02/02/2026 Quarterly MDS showed that Resident 107 re-admitted to the facility on [DATE] with diagnoses of muscle weakness, difficulty speaking, and a history of a non-traumatic brain bleed. Review of Resident 107's physician orders showed they had a CVC. The physician orders directed staff to change Resident 107's CVC dressing every seven days. Review of Resident 107's March 2026 treatment administration record showed the CVC dressing change was to be completed the morning of 03/11/2026. Observation on 03/18/2026 at 8:32 AM showed Resident 107's CVC dressing was in place and dated 03/09/2026. In an interview of 03/24/2026 at 9:45 AM Staff E stated they saw the 03/09/2026 overdue date on the CVC dressing for Resident 107 on 03/18/2026. Staff E stated it was important to change the dressings every seven days as ordered since the catheter went to heart and without dressing changes, there was an increased risk for infections. In an interview on 03/24/2026 at 11:49 AM Staff B stated staff should have followed the physician orders for Resident 107 and changed the CVC dressing on 03/11/2026. <Resident 110> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 03/17/2026 admission MDS, Resident 110 readmitted to the facility on [DATE], had an unhealed pressure injury requiring treatment, and was dependent on staff for ADLs, including bed mobility, dressing, and toileting hygiene. In an interview on 03/18/2026 at 10:17 AM, Resident 110 said they had a sore on their bottom and staff sometimes put some cream on it for them. Record review showed Resident 110 had a 03/12/2026 physician order instructing staff to apply a medicated topical cream to the buttocks and rectum and place an ABD pad (a highly absorbent sterile dressing designed for covering large, heavily draining wounds) in the gluteal fold (the horizontal crease just below the buttocks) every shift. The 03/12/2026 order was discontinued on 03/19/2026. Record review showed a 03/19/2026 physician's order instructing staff to cleanse the pressure injury to Resident 110's rectum, apply a thick layer of medicated topical cream, and place an ABD pad to the area with every peri-care (toileting hygiene). Observation on 03/18/2026 at 1:03 PM showed Staff L (Certified Nursing Assistant – CNA) provide peri-care for Resident 110. Observation showed Resident 110's incontinence brief was soiled with liquid feces, they had an open wound to their rectal opening, and no ABD pad was found. Staff L cleansed the area and applied a clean incontinence brief. No medicated topical cream or ABD pad was provided at that time. Observation on 03/23/2026 at 9:05 AM showed Staff M (CNA) provide a bed bath and peri-care for Resident 110. Observation showed Resident 110's incontinence brief was soiled with liquid feces, they had an open wound to their rectal opening, and no ABD pad was found. Staff M confirmed there was no ABD pad in place and stated they would inform the nurse. In an interview on 03/23/2026 at 10:19 AM, Staff O (Registered Nurse) stated Resident 110 had a wound to their rectum and they were to cleanse it and apply a medicated topical cream daily. Staff O said they were supposed to apply an ABD pad, but the ABD pad did not work well because it would become soiled with feces and did not stay in place. Staff O reviewed Resident 110's orders and confirmed the treatment was to be done with every peri-care. Staff O stated they did not perform the treatment yet today because they were passing medications. Observation on 03/24/2026 at 9:20 AM showed Staff N (CNA) provide peri-care for Resident 110. Observation showed Resident 110's incontinence brief was soiled with liquid feces, they had an open wound to their rectal opening, and no ABD pad was found. Staff N confirmed there was no ABD pad in place. In an interview on 03/24/2026 at 9:58 AM, Staff O stated they informed Staff B last week that Resident 110's ABD pads were not staying in place. Staff O stated they did not notify the provider or request a new treatment order. In an interview on 03/24/2026 at 10:20 AM, Staff G (RCM) stated they expected nurses to call the provider and obtain a new physician's order if the existing order was not working. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i).

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

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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. Based on observation, interview, and record review the facility failed to ensure 1 supplemental resident of 1 resident (Resident 6) reviewed for non-pressure skin alterations and 1 of 1 resident (Resident 5) reviewed for constipation/diarrhea (loose stools) were provided quality care and services. The failure to ensure resident skin issues were assessed, treated, and/or monitored, and the failure to initiate the facility bowel care protocol left residents at risk for unmet care needs, pain/discomfort from constipation, and a decreased quality of life.Findings included.<Facility Policy>Review of the facility's Wound Treatment Management policy, revised 01/2026, showed the facility would promote the healing of various types of wounds. The policy showed licensed staff would notify the physician and obtain treatment orders for wounds without treatment orders.<Non-Pressure Skin> <Resident 6> According to the 01/07/2026 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 6 had diagnoses including a progressive disorder causing cognitive decline, poor blood circulation to their lower legs, and muscle weakness. This MDS showed Resident 6 had impairment in range of motion to both arms and both of their legs. The MDS showed Resident 6 did not have any current skin conditions but was at risk for developing pressure ulcers. Review of Resident 6's physician orders showed a 02/01/2026 order directing staff to perform a weekly skin check to identify new skin issues. The order directed staff to document yes or no, make a progress note, and complete a weekly skin check assessment. Observation on 03/20/2026 at 8:38 AM showed Staff I (Certified Nursing Assistant - CNA) and Staff J (Restorative Aide) provided incontinent care to Resident 6. Observation at this time showed both of Resident 6's legs were contracted, bent severely at their knees and turned to the right side of the bed. At that time, Resident 6 told Staff I and Staff J their foot hurt. The inside edge of Resident 6's left foot and outside edge of their right foot were resting directly on the mattress. A reddened area was observed on the inner ball of their left foot below their great toe. Observation on 03/20/2026 at 9:04 AM showed Staff I and Staff J finished the incontinent care with Resident 6 and prepared to exit their room. Resident 6 stated they needed to see the nurse because their foot hurt. Staff J asked Resident 6 which foot hurt and Resident 6 stated their left foot hurt. In an interview on 03/20/2026 at 12:27 PM, Staff P (Registered Nurse) stated they were the nurse for Resident 6 that day. Staff P stated they were unaware of any new skin issues for Resident 6. Review of a 03/21/2026 weekly skin assessment showed licensed staff performed a skin check for Resident 6. The assessment showed no documentation related to redness on Resident 6's left foot. Observation on 03/23/2026 at 1:36 PM showed Resident 6 lying in bed, legs contracted and turned to the right side of the bed. At that time, Staff N (CNA) and Staff V (CNA) provided care to Resident 6. Observation showed the reddened area remained on the inner ball of their left foot below Resident 6's great toe. In an observation and interview on 03/24/2026 at 10:35 AM, Resident 6 stated their foot hurt while they were resting/sleeping in bed. Resident 6 stated the bottom of their left foot bothered them. Observation at that time with Staff W (Licensed Practical Nurse) showed Resident 6's left inner foot (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resting directly on the mattress. Staff W confirmed the reddened area and observed a second reddened area to the outside edge of Resident 6's left foot. Staff W gently pushed onto the reddened areas which were blanching (generally indicating healthy blood flow). In an interview at that time, Staff W stated the physician should be notified, the reddened areas should be monitored by staff, and staff needed to implement pressure relieving measures. In an interview on 03/24/2026 at 12:46 PM, Staff B (Director of Nursing) stated the process for weekly skin checks was for the nurse to perform the assessment, document any new skin issues and report the findings to the provider. Staff B stated they expected any reddened areas to be captured on the skin assessment so staff could obtain orders as needed and monitor the redness for changes. <Resident 5> According to the 02/12/2026 admission MDS, Resident 5 was dependent on staff for toileting and moving in bed. The MDS showed Resident 5 was always incontinent of bowel and had diagnoses including malnutrition and weakness and admitted to the facility with an open pressure wound (bed sore) with full thickness tissue loss and received their nutrition through a feeding tube. Record review showed Resident 5 had physician's orders for two regularly scheduled medications to treat constipation: a 02/06/2026 order for a powdered constipation medicine twice a day through the resident's feeding tube, and a 02/06/2026 order for a constipation medication in tablet form twice a day through the resident's feeding tube. According to the 02/09/2026 tube feeding Care Plan (CP) staff should monitor and report any diarrhea. According to the 02/10/2026 weekly skin assessment, Resident 5 had a dressed, opened wound on their coccyx (tailbone area). According to the revised 02/19/2026 at risk for bowel incontinence. CP, Resident 5's goal was to be free of skin breakdown caused by incontinence. The CP showed staff should help clean Resident 5 after every incontinence episode. According to the actual impairment to skin integrity. CP, staff should keep Resident 5's skin clean and dry. According to the revised 03/16/2026 self-care performance. CP Resident 5 required total assistance from staff for toileting care. In an interview 03/18/2026 12:07 PM, Resident 5 stated they got constipated but took treatment that helped. Resident 5 denied loose stools. Observation at that time showed Resident 5 in bed, lying on their side with a pole to hold a feeding tube formula bag next to the bed. Review of bowel charting showed Resident 5 was documented to have loose stools on 02/20/2026 at 6:18 PM, on 02/23/2026 at 5:12 AM, on 02/26/2026 at 3:07 AM, on 03/01/2026 at 5:59 AM and on 03/02/2026 at 5:17 AM. Review of the February 2026 Medication Administration (MAR) showed Resident 5 was given both bowel medications in the morning on 02/20/2026 and 02/23/2026. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the March 2026 MAR showed Resident 5 was given both bowel medications in the morning on 03/01/2026 and 03/02/2026 In an interview on 03/24/2026 Staff B stated when a resident had a full thickness open wound, loose stools were a problem they could soil the dressing and the wound. Staff B stated it was important to avoid loose stools, including holding medications when the physician's order directed. Staff B stated the constipation medication should have been held on the above dates but were not. REFERENCE: WAC 388-97 -1060(1)-(3) .

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	505202	A. Building B. Wing	03/24/2026

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Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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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 observations, interviews, and record review the facility failed to ensure residents were free of accident hazards for 3 of 7 (Residents 26, 19, & 9) residents reviewed for accidents. This failure to ensure resident rooms were free of no longer needed safety interventions, resident mattresses were placed correctly on bed frames, and periodic safety assessments were completed placed residents at risk of injury, unmet needs, and diminished quality of life.<Facility Policy>According to the facility's revised 01/2026 Incidents and Accidents policy, falls and accidents would be investigated and new interventions determined to be necessary to prevent recurrence would be documented in the resident's record.Findings included.

<Resident 26>

According to the 02/12/2026 admission Minimum Data Set (MDS – an assessment tool), Resident 26 had impaired vision and intact cognition, and had a fall with no injury since admission. The MDS showed Resident 26 was frequently incontinent of bladder and always incontinent of bowel. The MDS showed Resident 26 took an anti-seizure medication.

Record review showed Resident 26 had a 02/07/2026 physician's order to check the placement of fall mats on both sides of their bed when unattended (discontinued on 03/12/2026) and a 02/09/2026 order for an anti-seizure medication prescribed for nerve damage/pain.

According to the revised 02/19/2026 at risk for falls. CP showed Resident 26 needed two therapists for practicing transfers and required the help of two staff to transfer with a mechanical lift. The CP showed Resident 26's bed should be kept in a low position and included a 03/18/2026 intervention for fall mats on both sides of the bed.

According to the 03/04/2026 fall risk assessment Resident 26 was at high risk for falls. The assessment showed Resident 26 fell on [DATE] and had fall risk factors including a fall within the last 90 days, highly/severely impaired vision, incontinence, attempts to get up/reposition from their chair/bed, and the use of medications associated with increased fall risk.

According to the facility's 03/04/2026 witnessed fall investigation, Resident 26 had an assisted fall during therapy. Resident 26 ended up with their knees on the ground and their upper body resting on their bed with their wheelchair behind them. Resident 26 told the nurse after grabbing the rail on their bed to transfer from their wheelchair, their leg locked up and they went down to the floor, stabilized by the therapist. Resident 26 stated they were not hurt and the investigation showed they were assessed with no injury. The investigation showed Resident 26 should now have two therapists to assist them with transfers and to continue therapy.

According to 03/12/2026 Interdisciplinary Team (a group of facility managers) progress note, Resident 26 no longer tried to get out of bed unassisted and was more compliant with care directions. This progress note showed Resident 26 no longer needed floor mats, and they should be discontinued and the CP updated, and showed Resident 26 was agreeable to the change.

03/18/2026 at 1:55 PM showed Resident 26 in bed with fall mats on both sides of their bed. In an interview at that time, Resident 26 expressed frustration that the facility required them to wait for
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2026
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to help them out of bed. Resident 26 stated they wanted to use a commode to toilet independently. Observation on 03/19/2026 at 9:55 AM showed Resident 26 in bed with no fall mats. The mats were again not present when Resident 26 was observed in bed on 03/20/2026 at 1:00 PM. In an interview on 03/24/2026 at 11:01 AM, Staff B (Director of Nursing) stated fall mats were necessary when Resident 26 first admitted because they were unpredictable and could roll out of bed. Staff B stated the facility determined they were no longer needed for Resident 26's safety and were discontinued. Staff B stated the charge nurse the prior weekend did not know the mats were discontinued and put them back in place. Staff B stated they were not sure where the charge nurse found the mats or if they were still in Resident 26's room when the charge nurse placed them back beside the bed. Staff B stated because the mats were no longer assessed to be necessary, they should not have been in place on 03/18/2026 when observed. <Resident 19> According to the 01/08/2026 Quarterly MDS Resident 19 had severely impaired cognition, and diagnoses including high blood pressure, dementia (a decline in mental abilities) and a vision problem. The MDS showed Resident 19 used a wheelchair and a walker and transferred from their bed to their wheelchair independently. The MDS showed Resident 19 used a diuretic (water pill) medication. According to the 02/03/2020 fall risk evaluation Resident 19 had fall risk factors including high blood pressure and use of a diuretic medication. Record review showed Resident 19 had active orders for two different diuretic medications both dated 12/15/2023. According the revised 07/06/2023 fall risk. Care Plan (CP) Resident 19 was at risk for falls related to their diuretic use, impaired cognition, and impulsiveness. The CP showed staff should assess Resident 19's fall risk quarterly and as needed. According to the revised 03/11/2024 self-care deficit. CP, Resident 19 was independent with transfers and bed mobility. Observation on 03/19/2026 at 10:38 AM showed some bundled fabric (consistent with clothing of some sort) wedged between the left corner of Resident 19's mattress and bedframe (as observed from the foot of the bed). This caused the left side of the mattress to be elevated five inches above the frame at the head of the bed and caused the mattress to slope to the right side at the top. Observations on 03/19/2026 at 12:58 PM and on 03/20/2026 at 8:18 AM showed the same bundle of cloth still elevated the left corner of the mattress from Resident 19's bedframe. Observation on 03/20/2026 12:52 PM showed Resident 19 making their bed independently. Observation on 03/20/2026 at 12:56 PM showed the bundled fabric still elevated the mattress from the bedframe. In an interview at that time, Staff A (Administrator) observed Resident 19's bedframe and mattress and stated the placement of the fabric bundle was an accident hazard and made the bed less safe. Staff A stated it was possible Resident 19 place the bundle under the mattress themselves, (continued on next page)

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	505202	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but they expected nursing staff to notice such potential hazards and correct them. <Resident 9> Review of Resident 9's 02/16/2026 Annual MDS showed Resident 9 re-admitted to the facility on [DATE] with diagnoses of a progressive neurological disorder that affected movement, muscle weakness, and a seizure disorder. The MDS showed Resident 9 used an electric wheelchair. In an observation and interview on 03/18/2026 at 10:10 AM Resident 9 was seen sitting up in their electric wheelchair with a seat belt in use. Resident 9 stated that the facility had not checked the seat belt, that it had come with the chair. Resident 9 stated they do not remember being assessed for use of the seat belt or ability to self-release the seat belt. In an interview on 03/24/2026 at 9:32 AM Staff H (MDS Coordinator) stated that a safety assessment of Resident 9's wheelchair seat belt should have been completed quarterly to ensure it was still an appropriate device. Staff E stated that due to Resident 9's neurological disorder their ability to self-release the device could diminish and result in Resident 9 being restrained in the chair. Staff E reviewed the health record for Resident 9 and found that they had safety device assessments on 10/05/2024 and 03/16/2026. In an interview on 03/24/2026 at 11:49 AM Staff B stated safety assessments of enabler/restraints should be completed quarterly by therapy if the devices are appropriate based on the residents' abilities and needs. Staff B reviewed the records for Resident 9 showed that safety assessments for their wheelchair seat belt were conducted in 2024 and 2026 and not quarterly. REFERENCE: WAC 388-97-1060(3)(g).