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	04/29/2019

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32898 Based on observation, interview and record review, the facility failed to provide residents with elements of a dignified lifestyle for two (#'s 31 & 74) of four and three (#s 19, 57 & 9) supplemental residents reviewed. Failure to close privacy curtains during personal care and toileting, provide privacy covers for urinary drainage bags, knock before entering resident rooms, and providing Resident #74 the ability to watch TV without his roommate being able to change the channel without his knowledge or permission, placed residents at risk for feelings of diminished self-worth, and embarrassment. Findings included . RESIDENT #19 According to the 01/23/19 Admission MDS (Minimum Data Set-an assessment tool), Resident #19 required extensive two person physical assistance with caring for his indwelling Foley catheter (a small flexible tube used to drain urine from the bladder), and turning and repositioning while in bed. On 04/22/19 at 8:58 AM Staff Q, CNA- Certified Nursing Assistant, and R, CNA, were observed at the resident's bedside. Staff R entered the resident room and failed to close the door or the privacy curtain, Staff Q proceeded to remove the sheet and the blanket exposing the resident's torso and disposable brief, which was visible from the hall. On 04/22/19 at 9:10 AM, Staff K, RCM- Resident Care Manager, entered the room and instructed staff to ensure privacy curtains were closed when providing personal care for residents. Staff K was asked if the facility had a policy regarding privacy bags for urinary drainage bags. According to Staff K, urinary drainage bags should be covered with a privacy bag. RESIDENT #57 On 04/29/19 at 8:17 AM, according to Staff J, Resident #57 was in the first floor dining room. Staff J entered the dining room and approached the resident sitting at the table and informed him that he needed to have a blood glucose test done and needed to take his morning medications with his meal. Two other residents were sitting at a table a few feet away. (continued on next page)

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

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	04/29/2019

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff J obtained a sample of blood for the glucometer test and handed the resident a plastic cup containing several pills. Take your pills, I'll give you a shot [insulin] after you finish your breakfast. In an interview on 04/29/19 at 8:22 AM, Staff J was asked if the facility had a policy regarding invasive procedures in the presence of other residents. Staff J replied, Yes , but it's his choice to do it in that room. He likes to get his pills and blood sugar test in the dining room, so he can have a cup of coffee before breakfast. A review of the resident's care plan revealed no documentation indicating the resident preferred to have medication and glucometer testing at a specific time or place. In an interview on 04/29/19 at 8:52 AM, Staff B, DNS-Director of Nursing Service, stated the resident should have been taken to a private environment, not only for infection control purposes, but out of respect for Resident #57 and the other residents in the immediate area. RESIDENT #74 In an interview on 04/24/19 at 10:09 AM, Resident #74's daughter stated she had some concerns related to her father and his roommate. According to the resident's daughter, he was unable to speak and also hard of hearing, and required the physical assistance of another person to change the channels on the TV to programming he enjoyed. Resident #74's daughter stated, If he [Resident #34] has his TV up loud my dad can't hear his program. Additionally, according to the resident's daughter, if Resident #74's roomate used his remote control to change the channel on his TV, the channel on both TV's would change, resulting in Resident #74 being forced to watch programing he didn't enjoy. In an interview on 04/26/19 at 10:39 AM, Staff EE, Maintenance Director, confirmed if Resident #34 used the remote control to change the channel on his TV, the channel on both TV's would change. Staff EE said, I'll put tape over Resident # 34's remote, [that should prevent it from controlling both TV's.] In addition, Staff EE said, I have to locate a remote control for his [Resident #74's] TV, this isn't the right one. 37044 RESIDENT #9 On 04/18/19 at 9:12 AM, after knocking and receiving permission to enter, Resident #9 was observed sitting on her bedside commode (BSC), with her pants around her ankles, exposing her from the waist down. The door to the resident's room was open, and the privacy curtain was not pulled. Similar observations of an open door and no privacy curtain were made of Resident #9 on the following dates: 04/19/19 at 9:23 AM; 04/23/19 at 9:38 AM; 04/24/19 at 9:15 AM; and 04/25/19 at 10:31 AM. (continued on next page)

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	04/29/2019

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/25/19 at 10:43 AM, Staff K, Resident Care Manager, indicated she was aware that Resident #9 was often on the bedside commode without her privacy curtain pulled, explaining [The privacy curtain] was broken, but I had it fixed. When informed that Resident #9 was currently on the BSC, without the privacy curtain pulled, Staff K stated the curtain should be pulled, but indicated Resident #9 did not seem to have an issue with it. When asked if it was a dignity issue for Resident #9, her roommate, and visitors of the roommate who had to walk by an exposed person using the bathroom, to visit their loved one, Staff K stated, Yes. RESIDENT #31 During an interview on 04/19/19 at 8:29 AM, Resident #31 was explaining that staff did not knock before entering his room. At that time of the interview, Staff P, Licensed Practical Nurse, was observed opening the resident's door and starting to enter the room without knocking. Staff P said, Sorry and exited the room. Resident #31 continued, As you can see they [staff] don't knock. REFERENCE: WAC 388-97-0860(1)(a)

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	04/29/2019

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on observation, interview and record review, the facility failed to allow three (#s 72, 31, & 3) of six residents reviewed for choices, the right to make choices regarding important daily routines and health care, including accommodating preferences for the frequency of bathing. The facility's failure to accommodate resident choice, placed these residents at risk for a diminished quality of life. Findings included . RESIDENT #72 Record review showed Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 Quarterly Minimum Data Set (MDS - an assessment tool), the resident was understood and able to understand conversation, had no rejection of care, and choices related to bathing were identified as, very important. During an interview on 04/18/19 at 10:31 AM, Resident #72 expressed she did not get to choose how often she was showered stating, [Staff] tell ya it is once a week, I would prefer seven days a week .but could settle for three a week, one is not good enough. Review of the facility shower schedule showed, Resident #72 was scheduled to receive two showers a week, on Tuesdays and Saturdays. Review of the bathing flowsheets for the last 90 days (01/18/19 to 04/20/19) showed, the resident was not consistently being provided showers two times a week as scheduled. Resident #72 went the following amount of days without being offered or provided showers: 01/20/19 -01/29/19 (10 days); 02/03/19-02/08/19 (6 days); 02/24/19-03/01/19 (6 days); 03/03/19-03/14/19 (13 days); and 03/17/19-03/22/19 (6 days). During an interview on 04/29/19 at 7:48 AM, Staff I, Resident Care Manager - RCM, explained that it was the expectation that residents' identified preferences for bathing be honored. When asked if Resident #72's bathing preferences were being honored Staff I stated, No. RESIDENT #31 According to the 01/24/19 Quarterly MDS, the resident was cognitively intact, able to understand and be understood in conversation, and choices related to bathing were assessed to be, very important. During an interview on 04/19/19 at 8:21 AM, Resident #31 explained that he was supposed to receive showers two times a week, on Wednesday and Friday .It is those days because I have dialysis on Tuesdays, Thursdays and Saturdays, and I am too tired after dialysis But I am still [only] getting one [shower per week.] (continued on next page)

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	04/29/2019

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the .ADL [Activities of Daily Living] self-care performance . care plan, updated 02/20/19, The resident is totally dependent on staff to provide bath/shower .Resident prefers to have showers/bed bath on Wednesday and Friday, resident prefers to have two showers a week . Review of the bathing flowsheets for the last 30 days (03/23/19-04/21/19) showed the resident was consistently only provided one shower a week. On the following scheduled shower days the facility failed to offer/provide a shower as scheduled: 03/27/19; 04/03/19; 04/12/19; 04/17/19; and 04/19/19. During an interview on 04/29/19 at 9:09 AM, when asked if Resident #31 was being provided showers per his identified preference, Staff I stated, No. RESIDENT #3 Resident #3 admitted to the facility on [DATE]. According to the Significant Change MDS dated [DATE], the resident was understood and able to make his needs known. This MDS indicated choices related to bathing were very important, and there was no rejection of care. During an interview on 04/19/19 at 8:59 AM, Resident # 3 said, I don't get that many baths/ showers. Maybe once a week, if I scream. But It doesn't happen automatically. I usually have to keep asking them for it. When asked how often he prefered to shower, Resident #3 stated, a couple times a week would be good, but they [staff] said you only get one bath/shower a week here. A review of the resident's care plan dated 09/08/18 revealed, the resident was dependent on the physical assistance of one person for bathing/showering assistance, and preferred to bath/shower weekly on Friday. A review of the POC (Point of Care) 30 day look back report revealed, between 03/29/19 and 04/19/19, staff documented the resident received a bed bath on 03/29, 03/30, 04/05/19. On 04/08/19 staff documented the resident received a shower on 04/09/19, with no bathing offered for 10 days, when a shower was documented as refused on 04/19/19. During an observation on 04/24/19 at 1:30 PM, the resident was observed lying in bed, his hair was disheveled and he had 3-4 days growth of facial hair. Staff J said, he needs to be cleaned up, he also needs his facial hairs removed and his hair brushed. 37044 REFERENCE: WAC 388-97-0900(1)(3). 40303

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	04/29/2019

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to have a system in place to promptly resolve grievances for one (# 72) of two residents reviewed for missing personal property. Failure to timely address and/or follow-up with resident's concerns related to missing property, and care and services, placed the resident at potential risk for continued care concerns and a diminished quality of life. Findings included . Refer to CFR 483.12(c)(2)-(4), F-610, Investigate Abuse/Protect Resident During Investigation According to the facility Resident Rights grievances policy, revised, 01/2019, residents have the right to file grievances related to care, services or other aspects of life in the facility.[the facility] will investigate and take actions, as needed, to address such grievances .Staff will immediately report to the Grievance Officer (Administrator) any grievance that alleges violations related to potential neglect, abuse .The Grievance Officer will take immediate action to prevent potential violations of any resident right while the grievance is investigated. The resident, or person filing the grievance on behalf of the resident, will be informed of the findings of the investigation and actions that will be taken to correct any identified problems. The Grievance Officer and or designee, will make such reports available within seven business days of the filing of the grievance with the facility. RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 Quarterly Minimum Data Set (MDS - an assessment tool), the resident was understood and able to understand, with clear comprehension. During an interview on 04/18/19 at 10:38 AM, when asked about missing property Resident #72 expressed she was missing a stuffed bear that had belonged to her daughter, since she was seven .I had it here and now it is missing .my daughter cried when she heard, some [stuffed animals] were found but not that one . and an old family photo that I had on the window sill is still missing. When asked if she reported these issues to staff Resident #72 indicated she had, and her sister also filed (grievance) forms. Review of the facility grievance log showed on 03/23/19 and 04/13/19, grievances were logged for Resident #72. Review of the 03/23/19 Grievance Report, filed by the resident's sister on her behalf, showed that multiple grievances were included on this document. According to the 03/23/19 grievance Resident #72 was missing a precious belonging .[a gray, well loved koala bear with no eyes] .it's a simple little thing, not valuable, but very sentimental and irreplaceable from her children's childhood. It was a significant source of emotional comfort to her . The document also indicated the resident was missing a stuffed mouse, pink Koala bear hugging a heart, and a family picture in a 70's style frame, that was removed from her window sill. (continued on next page)

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	04/29/2019

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility staff documented in response, Went and spoke with [Resident #72], she states she is missing a pink Koala holding a heart and a gray koala without eyes that is [AGE] years old. She is also missing a photo about 4 x 3 or smaller that is in a 70's type frame with 3 kids in the picture, 2 girls and one boy. The boy is holding the top of one of the girls heads, he is wearing a leather vest and one of the girls is blonde. Her other stuffed animals have been found We will continue to work on missing items and speak with family about possible replacements if needed and able. The grievance investigation did not include where the other stuffed animals were found, how they got there, interviews with staff to determine who moved the stuffed animals and photo without the resident's permission, or any education with staff members related to not moving resident personal belongings without permission. During an interview on 04/26/19 at 9:45 AM, Staff I, Resident Care Manager, stated she was the staff member who investigated the above grievances. When asked where the other stuffed animals were found Staff I stated, In her closet. When asked how they got there Staff I stated, I have no idea. When asked if she interviewed staff about who moved Resident #72's belongings or educated staff not to move resident's belongings without their permission Staff I stated, No and indicated this should have been done to identify the cause of the issue, and to prevent reoccurrence. Additionally, when asked if the facility offered to replace the missing items that were not found, as stated in the grievance summary, Staff I indicated she was unsure. Documentation of the offered/provided reimbursement was requested, but none was provided. The 04/13/19 grievance expressed concern about Resident #72, not receiving her medications on time. The facility response stated, Med[ication administration] times have been printed out and does not appear to receive medications late. However, review of the printed medication administration times showed, on 04/11/19 the resident received her 12:00 AM Clonazepam (an anti-anxiolytic) at 2:09 AM, and on 04/12/19, received it at 2:02 AM, greater than two hours late. Thus, the facility's finding that the resident does not appear to receive medications late was an inaccurate conclusion. The facility's failure to identify that Resident #72 was receiving her medications late, precluded them from taking action to remedy the situation. During an interview on 04/26/19 at 9:45 AM, when asked if she felt these grievances were thoroughly investigated and promptly resolved Staff I stated, No. REFERENCE WAC 388-97-0460 (1)(2).

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	04/29/2019

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to timely investigate allegations of abuse, neglect, and trendable incidents as potential resident neglect. Failure to timely and thoroughly investigate these incidents, prevented the facility from providing timely interventions to prevent further recurrence for Resident #s 20 and 72. Findings included . Refer to CFR: 483.21(b)(3)(ii)(iii), F-658, Services Provided Meet Professional Standards 483.25, F-684, Quality of Care FAILURE TO INVESTIGATE ALLEGATIONS RESIDENT #20 Resident #20 admitted to the facility on [DATE] and according to the 01/25/19 Significant Change Minimum Data Set (MDS-an assessment tool), was determined to be cognitively intact and able to understand and be understood in conversation. Staff determined the resident had no noted behaviors and no refusal of care. Observations on 04/26/19 at 11:50 AM, revealed Resident #20 being transferred from bed to wheelchair via a mechanical lift. In an interview on 04/26/19 at 12:15 PM, Resident #20 indicated staff frequently did not provide incontinent care or toileting when requested. A progress note dated 01/13/19 at 6:46 PM showed, Resident noted with stage I [pressure ulcer] to coccyx with excoriation around skin. Tx [treatment] started to clean with NS [normal saline], pat dry, apply skin prep to periwound . A subsequent progress notes dated 01/13/19 at 7:04 PM revealed the resident was, screaming out for the LN [Licensed Nurse] but NAC [Nursing Aide Certified] is in the room, asked her why she was screaming out for the LN and she states NAC has been gone for 2 hours and she is repeating the phrase, 'He's been gone for 2 hour [sic],' and not allowing any of us to talk to her. Informed resident that staff will be back [when] she calms down. Day shift LN and I walked into the resident's room when she asked to see LN the beginning of the shift when she stated she is voiding larger than normal amounts because her beddings (sic) get wet. Advised NACs to ensure adult protective wear is well aligned. It is the NAC in question who informed us resident wanted to see the LN. In an interview on 04/26/19 at 8:53 AM, Staff C, Corporate Nurse, indicated that given the resident's excoriated coccyx and wet bedding, facility staff should have investigated to ensure the resident's briefs were changed timely, as failure to do so could result in decline in skin condition and over saturation of briefs resulting in wet bedding. (continued on next page)

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	04/29/2019

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 7:58 PM 01/13/19 progress note indicated the resident had called the police, .states she has been neglected by the nurse .I went to the resident and told her I would give her a green form [grievance form]. She asked me why and I told her and she stated she told the police NAC neglected her. Resident given green form and call made to DNS [Director of Nursing Services] .Resident on alert for change in health status. Resident assigned to another NAC. In an interview on 4/26/19 at 8:53 AM, Staff C, Corporate Nurse, reviewed the grievance and abuse logs revealing no entries for Resident #20 for 01/13/19. At this time, Staff C indicated, based on the progress notes, an investigation should have been initiated to rule out neglect. FAILURE TO THOROUGHLY INVESTIGATE RESIDENT #20 According to the 11/13/18 quarterly and 01/25/19 Significant Change MDSs, Resident #20 required extensive two person assistance with bed mobility, transfers, and toileting. The resident was determined to be incontinent of urine. According to facility investigative documents dated 11/20/18, the resident was identified with an open area to right inner buttock which was excoriated in appearance, not on a bony prominence and, she is incontinent of bladder which could be a factor. Staff identified the resident was totally dependent on staff for, bed mobility and repositioning which could be a factor. According to the 11/20/18 investigative documents, when prompted for, information on what caused the resident skin condition staff documented, Res resistant to ask for assistance with toileting. Soften skin from improper hygiene (self-hygiene) . Facility staff completing the investigation failed to identify the resident was totally dependent on staff or toileting, pericare and personal hygiene, thus staff, not the resident, were responsible to ensure this care was provided. In an interview on 04/26/19 at 11:30 PM, Staff B, DNS, indicated staff provision of care, or lack there of, should have been considered as a contributing cause to the resident's skin breakdown. A skin interview questions for staff, roommate and family members form, attached to the 11/20/18 investigative documents, was completed by a staff member, who documented, I didn't notice any skin issues at that time. There was no indication of who the staff member was, what role the staff member had, or what, at that time meant. In an interview on 04/26/19 at 11:30 PM, Staff B stated that it would be important to know the staff member's role and what time that staff member didn't notice any skin issue, to determine the timeline of when the injury occurred. Another staff member documented, Resident leans to her right side when she is in her chair as a potential contributing cause to the skin injury. There was no indication facility staff attempted to identify whether the resident received the assistance with positioning she was assessed to require, or if this was a contributing factor to the skin injury. (continued on next page)

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	04/29/2019

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the investigative summary, staff identified the cause of the injury as, Resident incontinent of bladder and bowel .Resident self-transfers herself without assistance and acknowledgment of staff. Resident improper cleansing of her peri/rectal area during self-care, could invite moisture to settle in those areas to increase the risk of developing MASD [Moisture Associated Skin Damage]. Staff documented, Resident reports using restroom without the knowledge of the staff. Improper peri-hygiene after self-titling implied, which could lead to constant moisture in said areas. A 11/21/18 wound consult document identified the wound as a 3.5 x 1.5 cm MASD wound. In an interview on 04/26/19 at 11:30 PM, Staff B, confirmed the resident was dependent on staff for transfers and toileting, requiring a mechanical lift for transfers and the resident was not capable of self toileting. When asked if the resident could independently get to the bathroom, Staff B replied, I don't think so. In an interview on 04/26/19 at 11:30 PM, Staff B, indicated the investigation was not thorough. FALL #1 According to investigative documents dated 11/30/18, Resident #20 was found on the floor in the bathroom at 11:00 AM in an attempt to self-transfer. Staff documented the resident transfers from bed to electric chair via hoyer (mechanical lift). Staff identified the mechanical lift did not fit in the bathroom and A bedside commode was offered however she refused. Staff concluded, [if] the care plan was followed this fall could have been prevented if [resident] had requested assistance. According to the 11/30/18 investigation, staff identified multiple medication changes in the last week: an increase in the medication Glipizide on 11/27/18, was started on Lipitor on 11/26/18, started on Metformin on 11/28/18 and had an increase in lyrica on 11/28/18. Staff identified the resident was on antidepressant, laxative, narcotic and seizure medications in addition to the addition of the mentioned medication. However, there was no consideration or ruling out these medications specific side effects as contributing to the fall. According to the fall scene investigation report dated 11/30/18, the resident had regular socks on, not gripper socks. A fall witness interview form indicted the resident had gripper socks on. There was no indication facility staff identified or further investigated this discrepancy. Staff did not address how the resident, who was identified as dependent on staff for dressing, obtained non grip socks. According to the investigative summary, the resident pulled the call light in the bathroom after she had landed on the floor. However, according to a witness statement, the staff who identified the resident on the floor in the bathroom documented, she [had] not used call light. Staff indicated the cause of the fall as footwear, medications, vision, medical status, and mood or mental status documenting, Res had 8 medication changes within the month of November [2018], which could have a big effect on her judgement and behavior. Staff identified that every two hour toileting was already in place, yet the summary indicated the care plan was updated to offer toileting every two hours while awake. The fall scene investigations report, identified the resident was last toileted at 7:30 AM, three and one half hours prior to the fall, but there was no indication facility staff attempted to discern who should have toileted the resident at 9:30 AM. (continued on next page)

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	04/29/2019

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/26/19 at 11:30 AM, Staff B indicated this investigation could have been, more thorough. FALL #2 According to investigative documents dated 12/07/19, the resident was noted on the floor next to her bed at 8:50 PM. According to the summary, the resident was wearing nonskid footwear at the time of the fall. However, according to the fall scene investigation report dated 12/07/18, the resident had, bare feet in bed. A fall witness interview statement dated 12/07/18, indicated the resident had grip socks. The investigation did not identify the multiple discrepancies of types of footwear, or address if the resident should have had non-skid socks, or how the footwear might have contributed to the fall. According to the typed summary (undated), staff documented, she was getting up to use the restroom. She was last provided care at [6:30 PM] when she requested to be lain [sic] down after supper. Staff did not address if the last care provided at 6:30 PM included toileting. According to the Fall Scene Investigation Report, staff documented the last time the resident was toileted was 0700 [7:00 AM] but also reflected PM. Staff did not clarify this discrepancy. According to the investigative summary, the resident understands risks vs. benefits of self-transferring. A fall witness statement indicated the resident thinks she is independent and she can walk herself. The summary also indicted the care plan updated to reflect offer assistance with toileting every 2 hours . but did not address this intervention was already in place prior to the 11/30/18 fall. There was no indication facility staff determined if this intervention was implemented or if it was effective. In an interview on 04/26/19 at 11:30 AM, Staff B indicated this investigation could have been, more thorough and did not address if previous interventions were implemented or effective. FALL #3 Investigative documents indicated Resident #20 was found on the floor on 01/05/19 at 12:45 AM in her room, after an attempt to stand and walk to the bathroom was unsuccessful. Staff documented, She had used her call light to request assistance to use the bathroom. Staff had arrived to provide assistance by offering a bedpan secondary to staff helping other residents and she requires a Hoyer lift for transfers. This was at 12:30 AM. The CNA [Certified Nursing Assistant] left the room to get the other CNA they returned at 12:45 to find her on the floor . While the investigation identified some recent medication changes, staff failed to identify the resident had received contraindicated medications since 12/28/18, resulting in symptoms of Seratonin Syndrome, including change in cognition, agitation, restlessness, loss of muscles coordination and decreased level of consciousness. Had the 01/05/19 fall investigation been timely and thoroughly completed by day five (01/10/19), facility staff would have notified the physician prior to 01/14/19 when the contraindicated medication was identified and discontinued. (continued on next page)

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	04/29/2019

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation concluded, this fall could have been prevented had staff not taken 15 minutes to respond to her request to toilet. Because of this I think the best course of action is to educate the staff involved. In an interview on 04/26/19 at 11:30 AM, Staff B was asked which staff were involved and what education they received. No information was provided. FALL #4 Investigative documents dated 01/06/19 indicated the resident thought she was at home, got up and fell . The summary indicated, On 12/26/18 she was seen at her pain clinic for a routine follow up. The oxycodone was reduced to 10 mg at HS and start Tramadol 50 mg QID. There however was a [computer] generated interaction with her Duloxetine. The physician was notified, and she was placed on Mirtazapine instead of Duloxetine and continue the Tramadol and oxycodone. Record review revealed this was not correct and the resident received the Duloxetine and Tramadol from 12/28/19 through 01/14/19. The Duloxetine was only discontinued on 01/14/19 after the resident was identified to experience the adverse side effects identified with, the aforementioned interaction with the Duloxetine. Had the 01/06/19 fall investigation been timely and thoroughly completed by day five (01/11/19), facility staff would have notified the physician prior to 01/14/19, when the contraindicated medication was discontinued. RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 Quarterly MDS, the resident was understood and able to understand, with clear comprehension. In an interview on 04/18/19 at 10:38 AM, Resident #72 expressed concerns about not receiving her cream for her rash in her (peri area), and stated that this had also been reported to facility staff. Review of the Abuse/Incident Log revealed no indication facility staff investigated Resident #72's concerns of staff neglecting to provide an ordered treatment. Review of the facility Greivance log revealed, an entry for Resident #72 dated 03/23/19. The 03/23/19 grievance form, submitted by Resident #72's family, stated, [Resident #72] has a severe rash in her diaper area and this is the 3rd Saturday the aides were saying, 'You need some fungal cream.' Since it's been worse by the week, it's apparent there was no fungal cream applied .Today [Staff P, Licensed Practical Nurse] brought a tube to her room and applied it . The facility's response to the 03/23/19 grievance stated, [Resident #72] had a small amount of redness and [Staff P, Licensed Practical Nurse] noted it, and got an order for fungal powder . The investigation did not include interviews with CNAs (Certified Nursing Assistant) or nurses to corroborate or refute whether the rash had been present, worsening, and/or untreated for three weeks as alleged. According to the March 2019 Treatment Administration Record (TAR), no order for an antifungal powder was ever obtained or provided, as stated in the grievance summary. (continued on next page)

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	04/29/2019

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/26/19 at 9:45 AM, when asked if order for the antifungal powder was ever obatined after the 03/23/19 grievance, Staff I stated, No. Staff I also acknowledged that she failed to, but should have, interviewed staff members involved in Resident #72's care, to determine if the rash had been present and worsening for three weeks without treatment. When asked if she felt this allegation was thorouhgly investigated and timely resolved Staff I stated, No. Three weeks later, a second Grievance Report dated 04/13/19, continued to allege staff failed to treat Resident #72's identified fungal infection stating, [Resident #72] has no order for antifungal per her chart. [Staff P] told me last weekend he would make a request for it, and there is no order in the chart .she has a very painful rash [to the groin] that requires a [treatment]. Why does no one initiate .[illegible]. In response to the 04/13/19 greivance, the facility documented, Her skin sheets are clear . However, April TARS revealed staff obtained an order for antifungal cream on 04/16/19 to buttocks and groin for worsening redness x 14 days, every shift . and, Started an order for antifungal cream to buttocks and groin for worsening redness . There was no investigation as to why staff did not implement the antifungal after the 03/23/19 grievance, there was no interviews or investigation as to why nursing staff documented, skin sheets were clear, when the resident and family continued to express concerns about an existing yeast infection, no interviews of direct care staff regarding the resident's skin condition and a failure to consider or rule out neglect. The 04/13/19 grievance aslo included a concern that stated, [Resident #72] is supposed to have exercise six times a week and she was only getting it three times . A .Resident has limited physical mobility CP, initiated 09/15/18, directed staff to provide active ROM (Range of Motion) to BUE (bilateral upper extremities), to all planes of joints, using two pound weights for 3 sets of 10 repetitions, six times a week; and crossing midline reaching exercises, 10 repetitions, while sitting upright on wheelchair, six times a week. The facility's response stated, Printed out acceptance of restorative program, see papers. It can be offered 6 times a week. The response failed to address the allegation that Resident #72 was not being offered/provided the program six times a week, as she had been assesed to require. Review of the Restorative documentation from 04/07/19 to 04/13/19 showed, the resident was only offered/provided her restorative ROM program two times during the seven day period, instead of the six times she was assessed to require. The facility's failure to thoroughly investigate, resulted in staff not identifying that Resident #72 was not being provided her restorative program at the frequency she was assessed to require. Failure to identify this, precluded staff from implementing interventions to remedy the issue. REFERENCE: WAC 388-97-0640(6)(a)(b). 37044

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	04/29/2019

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to ensure a system by which residents received required notices at the time of transfer/discharge, or as soon as practicable, for two (Resident #62 & 66) of five Residents reviewed for hospitalization . Failure to ensure notification of the resident and the resident's representatives of the reasons for the move in writing and in a language and manner they understood, placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care, and preferences. Findings included . According to the facility policy for Admission, Transfer and Discharge, dated 07/20/18, If the transfer/discharge is for the safety of individual in the facility, the health of the individuals in the facility, the resident's urgent medical needs .or the resident has not resided in the facility for 30 days, the notice will be made as soon as practicable before the transfer discharge. According to the policy, the notice will include: the reason for transfer/discharge; location to which the resident was transferred/discharged ; a statement of the resident's right to appeal, contact information for the Office of the state Long-Term Care Ombudsman; contact information for the agency responsible for the protection and advocacy of individuals with developmental disabilities, if applicable; and contact information for the agency responsible for the protection and advocacy of individuals with a mental disorder, if applicable. This policy further indicated the medical record will contain evidence of notification being sent to the Ombudsman and emergency transfer to an acute care facility, is a facility initiated transfer and a notice of transfer must be provided to the resident/representative as soon as practicable. RESIDENT #62 In an interview on 04/18/19 at 1:29 PM, Resident #62 stated he was hospitalized and readmitted to the facility, a few times. According to progress notes, Resident #62 was admitted to the facility on [DATE] and discharged to the hospital on 3/12/19, due to a blood sugar of 32. Record review revealed no transfer notification information was provided to the resident or resident representative. Record review revealed the resident was readmitted to the facility on [DATE], and was subsequently discharged to the hospital for medical needs on 03/30/19. The resident was readmitted to the facility on [DATE]. Record review revealed no transfer notification information was provided to the resident or resident representative for the 03/30/19 discharge. In an interview on 04/23/19 at 8:34 AM, Staff H, Resident Care Manager, indicated an, acute care transfer form was completed upon resident transfer to the hospital, along with an interact transfer form. When asked if there were any documents given to Resident #62 at the time of discharge, Staff H stated, No, we just put the information in the packet to go with them [to the hospital]. (continued on next page)

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	04/29/2019

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/29/19 at 8:45 AM, Staff B, Director of Nursing, indicated the facility admission, transfer and discharge policy directed staff to provide certain required information at the time of transfer to hospitals. According to Staff B, an Acute Care Transfer Form was completed by staff at the time of transfers to the hospital and this document was scanned into the computer under the Evaluations section. Review of the electronic documents revealed no document for the resident's 03/12/19 or 03/30/19 discharge to the hospital. Staff B was requested to provide this information. No information was provided. In an interview on 04/29/19 at 9:01 AM, Staff B confirmed that Resident #62 had no Acute Care Transfer Forms for either discharge (03/12/19 or 03/30/19). RESIDENT #66 Resident #66 admitted to the facility on [DATE] and according to the 03/13/19 Quarterly MDS, was cognitively intact and able to understand and be understood in conversation. Review of progress notes revealed Resident #66 was discharged to the hospital on 04/25/19. An Interact transfer form was initiated on 04/25/19 but not completed. As of 04/26/19, the resident remained hospitalized and was not available for interview. In an interview on 04/29/19 09:01 AM, Staff B confirmed staff did not provide Resident #66 with the required information on discharge according to facility policy. REFERENCE: WAC 388-97-0120(1)(2). 40303

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	04/29/2019

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on interview and record review, the facility failed to provide a bed hold notice in writing at the time of transfer to the hospital, or within 24 hours of transfer to the hospital for two (#s 31& 86) of five residents reviewed for hospitalization . This failure placed residents' at risk for violation of their residents' rights, related to being informed of the bed hold policy. Findings included . Refer to CFR 483.15(c)(3)-(6)(8), F-623, Transfer and Discharge Requirements According to the facility's 07/2018 Admission, Transfer and Discharge Notice of Bed Hold Policy, The facility will provide written information to the resident or resident representative specifying the duration of the state bed-hold policy, if any, during which time the resident is permitted to return and resume residence in the facility. The information will also include a) the reserve bed payment policy in the state plan; b) the facility's policies regarding bed-hold periods .Two notifications will be provided. The first one well in advance of any transfer and the second one at the time of the transfer. The second notice will be provided to the resident and resident representative at the time of transfer or within 24 hours if the transfer was an emergency. In the event the facility is unable to reach the representative, the facility will document the attempts made . RESIDENT #31 Record review revealed Resident #31 admitted to the facility on [DATE]. Record review showed the resident was discharged to the hospital on 01/31/19 with, return anticipated. Review of the record and discharge nurses note revealed, no indication the facility provided Resident #31 or his representative, information regarding the bed hold policy. During an interview on 04/25/19 at 7:45 AM, when asked to provide documentation to support the resident or resident representative was notified in writing of the bed hold policy as required, Staff Y, Admissions, stated, I can't find one for him. When asked if there was any indication one was provided, Staff Y stated, No. RESIDENT #86 Record review revealed Resident #86 admitted to the facility on [DATE], and was discharged to the hospital on 01/23/19. A review of documentation in the electronic medical record dated 01/23/19, revealed no indication staff provided the resident or his representative information related to the facility's bed hold policy. (continued on next page)

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	04/29/2019

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/25/19 at 11:42 AM, Staff Y was asked if the resident or his representative had been notified of their rights related to bed hold Staff Y replied, I usually make a general note in the resident's record indicating bed hold information was provided. However, I'm unable to locate the notes. REFERENCE: WAC 388-97-0120 (4)(a)(b)(c) 37044

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	04/29/2019

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 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** 20264 Based on interview and record review the facility failed to accurately assess five (#s 33, 20, 31, 72 & 57) of 21 residents reviewed. Failure to ensure accurate assessments regarding diagnoses (# 33, 20 & 72), medications (# 72), refusal of care/behaviors (# 31), and vision (# 57), placed residents at risk for unidentified and/or unmet needs Finding Included . RESIDENT #33 According to the Quarterly Minimum Data Set (MDS- an assessment tool) dated 02/19/19, Resident #33 was admitted to the facility on [DATE] with care needs associated with Dementia and no anxiety disorder, no psychotic disorder and no noted episodes of hallucination and delusions. A review of Physician progress notes dated 06/20/18, indicated the resident had a diagnosis of dementia with psychosis, accompanied by confusion and poor memory. A review of the Medication Administration Record (MAR) dated April 2019 revealed, instruction to administer Seroquel (Quetiapine Fumarate) an antipsychotic medication 12.5 mg (milligrams) daily. In an interview on 04/2219 at 1:26 PM, Staff K (RCM- Residential Care Manager) said, he was taking Seroquel twice a day, 12.5 mg in the AM and 25 mg at night, for hallucinations and paranoia. In an interview on 04/23/19 at 1:00 P.M. Staff D, (MDS-Coordinator) was asked why the resident was receiving an antipsychotic medication. Staff D, said, he's receiving the medication, related to delusions and fearfulness of being harmed by gangsters and vicious dogs. According to Staff D, she didn't think she had to code the resident as having psychotic disorder (other than schizophrenia). RESIDENT #20 Similar findings were identified for Resident #20, who, according to Medication Administration Records (MARs) received Duloxetine (an antidepressant medication) daily for Depression from 10/25/18 through 12/26/18. However, according to the 11/13/18 Quarterly MDS, staff assessed the resident received antidepressants daily, but had no depressive disorder. 32898 RESIDENT #31 According to the the 01/24/19 Quarterly MDS, the resident had no behaviors or no rejection of care. Record review showed Resident #31 refused a shower on 01/18/19, and refused his restorative program on 01/23/19, both refusals occurred during the assessment period. (continued on next page)

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	04/29/2019

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/19 at 10:33 AM, when asked if the MDS was correctly coded Staff D, MDS coordinator, stated, No. Similar findings were noted on the 02/15/19 5 day MDS, in which staff coded no rejection of care. Record review showed Resident #31 refused a shower on 02/13/19, during the assessment period. During an interview on 04/24/19 at 10:33 AM, when asked if the MDS was correctly coded Staff D stated, No. RESIDENT #72 According to the 12/20/18 Quarterly MDS, the resident had diagnoses including bipolar and anxiety disorders, and received anti-anxiety medication on seven of seven days, but no anti-psychotic medication. Review of the December 2018 MAR showed, Resident #72 received Lurasidone (an anti-psychotic medication) on seven of seven days during the assessment period. During an interview on 04/24/19 at 10:30 AM, when asked if the 12/20/18 Quarterly MDS accurately reflected the resident's antipsychotic use, Staff D stated, No. According to the 12/20/18 and 03/22/19 Quarterly MDSs the resident had an active diagnosis of bacteremia, but did not receive any antibiotics. Record review revealed Resident #72 admitted on [DATE], with a diagnosis of urinary tract infection with bacteremia, and was successfully treated with antibiotics. In an interview on 04/29/19 at 10:18 AM, when asked if bacteremia was an active diagnosis for Resident #72 Staff D stated, No, they (12/20/18 and 03/22/19 Quarterly MDSs) are incorrect. RESIDENT #57 According to the 03/22/19 Admission MDS, Resident #57 admitted to the facility on [DATE] could understand and be understood in conversation, had impaired vision and utilized corrective lenses. In an interview on 04/19/19 at 9:31 AM, Resident #57 stated he was blind in one eye, stated he needed glasses and that his glasses were missing. The resident elaborated he never brought his glasses to the facility. In an interview on 04/24/19 at 10:59 AM, Staff H, RCM, stated, I live on this hall and I haven't seen any glasses. Staff H confirmed the Glasses marked section was answered by staff as not applicable on the personal inventory form dated 03/15/19. In an interview on 04/29/19 at 1:11 PM, Staff F indicated the MDS was incorrect. REFERENCE WAC 388-97-1000 (1)(a) 37044

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	04/29/2019

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level II comprehensive evaluations were obtained for two (#s 57 & 72) of six current sampled residents reviewed for PASRR evaluations. This failure placed residents at risk for not receiving necessary mental health care and services. Findings included . RESIDENT #57 Record review revealed, Resident #57 admitted to the facility on [DATE]. According to the 03/22/19 Admission Minimum Data Set (MDS - an assessment tool), the resident had diagnoses including depression and schizophrenia, but no anxiety disorder. This MDS indicated the resident had not been evaluated for a Level II PASRR, but was determined to have a serious mental illness (SMI). According to the PASRR Level I, dated 3/15/19, Resident #57 had Schizophrenia and anxiety disorder and required a Level II evaluation for SMI. In an interview on 04/23/19 at 9:56 AM, Staff G, Social Services, there was no indication facility staff referred Resident #57 for a Level II evaluation. On 04/23/19 at 10:38 AM, Staff G stated, I missed it, I didn't send it in. 37044 RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 09/13/18 Level I PASRR, the resident had diagnoses to include bipolar disorder and anxiety disorder. The document stated, No Level II evaluation indicated at this time due to exempted hospital discharge. Level II must be completed if scheduled discharge does not occur. Under .criteria for exempted hospital discharge . the physician documented .SNF [Skilled Nursing Facility] stay anticipated to be less than 30 days. Record review showed no indication the Level II PASRR was completed as directed, when the resident did not discharge in 30 days. During an interview on 04/23/19 at 10:47 AM, Staff G explained that Resident #72 should have been referred for a Level II evaluation Right after 30 days, but was not. Per Staff G she identified this, and made the referral awhile ago but had not received the results of the evaluation. On 04/26/19 at 10:42 AM, Staff G provided documentation that showed Resident #72 was not referred for a Level II evaluation until 02/11/19, approximately four months late, and that the Level II evaluation was performed on 03/12/19, but she had not received the results until now, due to providing an inaccurate email address. REFERENCE: WAC 388-97-1915 (4).

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	04/29/2019

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 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** 20264 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to, or upon admission to the facility, for three (#s 20, 33, 31) of six residents reviewed for PASRRs. This failure had the potential to place residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . Refer to CFR 483.20(e)(1)(2), F - 644, Coordination of PASRR and Assessments RESIDENT #20 Record review revealed Resident #20 admitted to the facility on [DATE]. According to the most recent 01/25/19 Significant Change Minimum Data Set (MDS - an assessment tool), Resient #20 had diagnoses including depression and received antidepressant medications on each day of the assessment period. According to the Level I PASRR dated 02/09/18, No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur. However, Section IIA of the Level I PASRR (Exempted Hospital Discharge) was blank. In an interview on 04/24/19 at 10:49 AM Staff G, Social Services, was asked if a Level II PASRR should be done if the resident wasn't discharged Staff G indicated she had completed an audit of the PASRRs stating, I identified residents who, to me, had Mental Illness, but hadn't gotten Level IIs and PASRRs weren't reflective of their current condition. I don't think I got to her [Resident #20] yet. Staff G indicated Resident #20's PASRR was, confusing and, yes it [PASRR] should have been redone last March to say something under exempted hospital discharge .Also it is not signed by the physician .its not complete. 32898 RESIDENT #33 Record review revealed Resident #33 admitted to the facility on [DATE]. According to the most recent Quarterly MDS, Resident #33 had a diagnosis of Non-Alzheimer's dementia and received an antipsychotic medication. According to the Level I PASRR dated 06/16/17, the resident had no serious functional limitation with, No Level II Indicated. On 07/02/18, staff documented the resident was started on a antipsychotic medication for hallucination and delusional thoughts. A review of Navos-Mental Health Provider notes dated 04/01/19, Resident #33 had a primary diagnosis of an adjustment disorder, with mixed anxiety and depressed mood. (continued on next page)

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	04/29/2019

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/19 at 10:49 AM, Staff G was asked if the Level I evaluation should have been re-done after the resident received a diagnosis of dementia with psychosis and anxiety with depressed mood. Staff G replied, yes, the PASRR Level I should have been re-done at the time of the new diagnosis. 37044 RESIDENT #31 Resident #31 admitted to the facility on [DATE]. According to the 01/24/19 Quarterly MDS, the resident had diagnoses to include depression and anxiety disorder, and received antidepressant and anti-anxiety medication on seven of seven days during the assessment period. According to the 06/20/18 Level I PASRR, Resident #33 was assessed with no serious mental illness indicators to include no depression or anxiety disorder. Review of Resident #31's current Physician's Orders showed a 03/23/19 order for Ativan (an anti-anxiolytic) every Tuesday, Thursday and Saturday before dialysis for anxiety, and a 10/26/18 order for Celexa (an anti-depressant) daily for Major Depressive Disorder. A Resident has psychosocial well-being problem: actual suicidal ideation . care plan, revised 01/30/19, directed staff to consult with Psych[ological] services .and monitor resident for safety checks for first 72 hours after alerted to actual suicidal ideation During an interview on 04/24/19 at 2:17 PM, when asked if the 06/20/18 Level I PASRR was accurate, Staff G stated, No and indicated that it needed to be redone. REFERENCE: WAC 388-97-1915.

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	04/29/2019

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to develop, review and or revise comprehensive care plans for nine (#s 57, 62, 3, 19, 33, 31, 72, 64, & 66) of twenty-one sample residents whose care plans were reviewed. Failure to establish care plans that were individualized, accurately reflected assessed care needs and provide direction to staff related to intravenous lines, discharge, end of life, oxygen, skin, vision, urinary care, behaviors, and medications placed residents at risk of unmet care needs related to inaccurate or inadequate direction to staff. Findings included . RESIDENT #57 Resident #57 admitted to the facility on [DATE] and according to the 03/22/19 Admission Minimum Data Set (MDS - an assessment tool), the resident received regularly scheduled and as needed pain mediation which didn't impact his ability to sleep at night. This MDS assessed the resident with one Stage III Pressure Ulcer (PU), one Stage IV PU and eight unstageable pressure ulcers. According to the resident's Kardex (part of the care plan with instructions to staff for patient care), staff were directed to provide bathing/showering twice a week on Tuesdays and Fridays. In an interview on 04/24/19 at 9:18 AM, Staff H, Resident Care Manager - RCM, reviewed the resident's bathing records and stated the resident received only three showers in 30 days with no refusals. Staff H indicated staff did not implement the Care Plan (CP) as directed. Record review revealed no CP developed which addressed the resident's pain issues or how pain impacted the resident's activities of daily living. In an interview on 04/24/19 at 9:18 AM, Staff H stated that, given the pain issues identified on the MDS, the CP should address pain. According to the Kardex, staff were instructed to Check mouth after meal for pocketed food and debris. Observation of breakfast meals on 04/22/19, 04/23/19 and 04/24/19, revealed staff did not check the resident's mouth after he ate independently with set up. In an interview on 04/24/19 at 9:18 AM, Staff H indicated this intervention was not current and should be removed from the CP. A Nutrition CP dated 03/18/19 indicated the resident required, 1:1 feed as resident allows. In an interview on 04/24/19 at 9:18 AM, Staff H indicated the resident did not require 1:1 feeding and the CP should be updated to reflect the resident's current clinical condition. Record review revealed a 03/19/19 CP problem of, The resident is (SPECIFY: independent/dependent on staff etc.) for meeting emotional, intellectual, physical and social needs r/t (if dependent). The listed CP goal was, The resident will maintain involvement in cognitive stimulation . In an interview on 04/24/19 at 9:18 AM, Staff H indicated the CP problem was not specific and, should be updated to reflect the resident's current status. Staff H indicated the CP goal was unclear stating, I don't think all the aides would know what that meant. (continued on next page)

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	04/29/2019

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions for the Social Needs CP included, Ensure that the activities the resident is attending are: compatible within physical and mental capabilities: compatible with known interests and preferences; adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), compatible with individual needs and abilities and age appropriate and The resident likes the following activities: (SPECIFY). In an interview on 04/24/19 at 7:42 AM, Staff W, Activities Director, confirmed the CP was not individualized and did not include pertinent, capabilities compatible with the resident's needs and abilities. According to a 03/25/19 CP, the resident was an elopement risk/wanderer. In an interview on 04/24/19 at 9:18 AM, Staff H stated, No, he's not, and indicated the CP needed to be updated. A 03/19/19 CP indicated, The resident is at risk for impaired cognitive function/dementia or impaired thought process. In an interview on 04/24/19 at 9:18 AM, Staff H indicated the resident did not have a diagnosis of dementia, and the CP was unclear as to what placed the resident at risk for impaired cognitive function. A 03/25/19 CP indicated the resident was, at risk for oral /dental health problems. In an interview on 04/24/19 at 9:18 AM, Staff H indicated the resident had actual oral/dental problems as evidenced by broken, carious teeth, and the CP should be updated. A 03/25/19 CP indicated the resident had, potential for dehydration r/t tube feeding, infection. Interventions included, Monitor and document intake and output as per facility policy. In an interview on 04/24/19 at 9:18 AM, Staff H indicated the resident was not on intake and output monitoring and the resident no longer received tube feedings and the problem needed to be resolved. A 04/12/19 CP indicated the resident had a respiratory infection and staff were directed to, encourage coughing, deep breathing and encourage fluid intake. When asked, in an interview on 04/24/19 at 9:18 AM, who provided these interventions and when they occurred, Staff H indicated the interventions should be clarified to be more specific as, I can't tell if this is happening. A 03/15/19 CP indicated, The resident uses psychotropic medications. In an interview on 04/24/19 at 9:18 AM, Staff H stated the CP should be more specific to include the type of psychotropic as side effects and behaviors should be specific to the medication received. Observations on 04/19/19 at 9:36 AM revealed the resident had dressings to both feet. According to a 03/19/19 CP, the resident, has potential for impairment to skin integrity r/t edema, fragile skin and included a goal of will maintain or develop clean an intact skin by review date. In an interview on 04/24/19 at 9:18 AM, Staff H stated the CP did not reflect the resident's actual alteration in skin integrity and the goal was not clear. RESIDENT #62 Resident #62 originally admitted to the facility on [DATE], discharged to the hospital on 03/12/19 and readmitted to the facility on [DATE]. The resident was again discharged on [DATE] and readmitted on [DATE]. According to the 4/16/19 5 day MDS, resident #62 was assessed to require extensive two person assistance with bed mobility and dressing, toilet use and personal hygiene. (continued on next page)

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	04/29/2019

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the resident's current Kardex, the resident required one person extensive assistance to turn and reposition in bed. In an interview on 04/25/19 at 8:55 AM, Staff H indicated this needed to be updated as the resident now required more assistance. According to the Mobility section of the Kardex, (SPECIFY type & location of bed rail) to assist resident to move about in bed. In an interview on 04/25/19 at 8:55 AM, Staff H stated the CP should reflect the type and location of the bedrail. Upon reviewing the rest of the resident's CP, Staff H reported the CP was not, but should have been, updated, after the last readmission to reflect the resident's care needs as it related to mobility, transfers, bed mobility, personal hygiene, toileting and ambulation status. 32898 RESIDENT #3 According to the 03/28/18 Admission MDS Resident #3 had care needs associated with recent bilateral lower extremity amputation. Review of the CPs dated 04/01/19 revealed the resident had an indwelling urinary catheter, with goals to be free from catheter related trauma through the next review date. Interventions listed on the CP included monitor/record/report to MD s/sx (signs and symptoms) of UTI (urinary tract infection). In an interview on 04/24/19 at 10:29 AM, Staff K, RCM, was asked if Resident #3 had an indwelling urinary catheter. Staff K replied,No. According to Staff K the care plan should have been updated to reflect the resident's catheter was discontinued. RESIDENT #19 Resident #19 admitted to the facility on [DATE]. A review of the resident's CP for Restorative Nursing Care revealed Bilateral Upper and Lower Extremities Passive ROM (range of motion) all joints and planes. A review of documentation on the Point of Care (POC) revealed staff documented the resident had several refusals of care. In an interview on 04/24/19 at 11:14 AM, Staff G, Social Services, was asked how the facility addressed the resident's refusals of services. Staff G said, Usually, when I'm aware that a resident refuses care .we develop a CP with goals and interventions to ensure the resident participates in or allows staff to provide care and services for them. Failure to develop a CP with goals and interventions addressing the residnt refusal placed the resident at risk of unmet care needs. RESIDENT #33 According to the 30-day Look Back Report Bathing records, Resident #33 refused bathing/shower assistance on 02/13, 02/17, 02/26 03/11, 03/25, 03/27, 04/03/19. In an interview on 04//25/19 at 12:09 PM. Staff K said, she wasn't aware of the resident's refusals bathing/shower assistance. (continued on next page)

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	04/29/2019

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff K, RCM, said, if he has documented refusals, then we should have developed a CP addressing his refusals and referred him to SS to follow up and provide risks and benefits to the resident. 37044 RESIDENT #31 A 01/30/19, .potential for fluid volume overload . CP directed staff to, Monitor and document intake and output (I&O) per facility policy, and Encourage resident to drink < [less than] 1.5 L[iters] per day. Record review showed no order for, or indication that Resident #31 was on I &O or a 1.5 L fluid restriction. Additionally, A 01/30/19 .needs hemodialysis . During an interview on 04/22/19 at 11:46 AM, when asked if Resident #31 was on I &O or a 1.5 L fluid restriction, Staff K, stated. No, and indicated the CP needed to be updated. Review of a 01/30/19 .at risk for oral/dental health problems . CP revealed, there was no direction to staff delineating who was to provide oral care or how much assistance the resident required. During an interview on 04/22/19 at 11:46 AM, Staff K indicated the CP should be resident specific and identify who was responsible for oral care and how much assistance (set-up vs physical assistance) the resident required. A 02/20/19 .ADL [Activities of Daily Living] self-care performance deficit . CP stated Resident requires extensive assist of one staff for eating, Observations throughout survey showed Resident #31 ate independently in the main dining room. During an interview on 04/22/19 at 11:46 AM, when asked if the CP was accurate Staff K stated, No. A 02/20/19 .ADL self-care performance deficit . CP stated, .The resident is totally dependant on two staff for personal hygiene and oral care. During an interview on 04/22/19 at 11:46 AM, when asked to explain why it took two people to comb Resident #31 hair or brush his teeth (Resident #31 was observed on 04/19/19 at 8:41 AM performing oral care independently) Staff K stated the CP was, Not accurate. A 02/20/19 .ADL self-care performance deficit . CP stated, ORAL CARE ROUTINE (AM, PC, HS): SPECIFY brush teeth, rinse dentures, clean gums with toothette, rinse mouth with mouth wash. However, staff failed to SPECIFY whether the resident had teeth or dentures or was edentulous as directed. During an interview on 04/22/19 at 11:46 AM, Staff K acknowledged the CP did not identify if the resident had teeth or dentures and indicated the CP should be resident specific. Record review revealed, a 01/30/19 activities CP that stated, The resident is (independent and dependant on staff etc.) for meeting emotional, intellectual, physical and social need r/t disease process. (continued on next page)

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	04/29/2019

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/19 at 11:46 AM, when asked how the resident could be both dependant and independent Staff K, acknowledged that the problem was not specific and should be updated to reflect the resident's actual needs. RESIDENT #72 Review of the April 2019 Medication Administration Record (MAR), showed a 03/15/19 order for Wound LLE [Left Lower Extremity], cleanse with NS [Normal Saline] cover with bordered foam or similar type dressing . Record review showed no CP had been developed addressing the identified wound. During an interview on 04/29/19 at 7:42 AM, Staff I, Resident Care Manager, indicated the wound had healed and then reopened. When asked if a CP should have been developed Staff I stated, yes and acknowledged this did not occur. A 04/01/19 .ADL self-care performance deficit CP, directed staff to Please help patient wear Posey boots on both Lower Extremities when she is sitting on the power chair . Resident #72 was observed throughout survey up in her power wheelchair without Posey boots in place. During an interview on 04/29/19 at 7:42 AM, Staff K stated, She hasn't had them [Posey boots] since she got her power wheelchair back .it was due to broken toes, but now she wears shoes, the CP should have been updated. RESIDENT #64 Record review revealed, a 12/31/17 CP that stated, The resident is edentulous [lacking teeth] has only one teeth [sic]. During an interview on 04/29/19 at 9:00 AM, Staff K acknowledged the CP was inaccurate, as the Resident could not both have teeth, and not have teeth simultaneously. A 12/26/18 The resident has limited physical mobility . CP stated, Grab bars on each side of bed to assist resident to move about bed. Observation of Resident #64 bed on 04/18/19 at 1:44 PM showed the resident had a grab bar on the right side of the bed only. Similar observations were made throughout survey. During an interview on 04/29/19 at 9:00 AM, Staff K acknowledged that the resident only had a grab bar on the right side of the bed. When asked if the CP was accurate Staff K stated, No. 40303 RESIDENT #66 According to the 03/13/19 Admission MDS, Resident #66 was cognitively intact and required one person physical limited assistance activity of daily living and personal hygiene. Review of Resident #66's CP revealed no activities goals or interventions in the CP. Observations on 04/19/19 at 9:00 AM revealed Resident#66 laying on his bed. At this time, Resident#66 said he would like to have a radio and access to the computer. (continued on next page)

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	04/29/2019

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/19 at 11:20 AM, Staff M, Activity Director, indicated she should have, but did not, develop a customized activity CP, including preferences, for Resident #66. On 04/26/19 at 1:30 PM Staff B, Director of Nursing, stated Activity Director is expected to ensure activity needs are care planned. REFERENCE WAC 388-97-1020(1), (2)(a)(b).

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice, for seven (#s 49, 62, 20, 19, 74, 31 & 72) of 18 residents reviewed. Nursing staff failed to: follow or clarify physicians' orders when indicated (#s 49, 62, 20, 19, 74, 31), document for only those tasks completed (#49, 31, & 72) and obtain consults and laboratory results for Resident # 72. These failures placed residents at risk for medication errors, delay in treatment, and adverse outcomes. Findings included . FAILURE TO FOLLOW/CLARIFY PHYSICIAN ORDERS RESIDENT #49 According to the 04/18/19 Significant Change of Condition Minimum Data Set (MDS - an assessment tool), Resident #49 had diagnoses of heart disease, heart failure, kidney failure, diabetes and lung disease. According to Physician Orders (POs) dated 03/01/19, staff were to administer Metoprolol (a cardiac drug) once a day and hold for .SBP [Systolic Blood Pressure)] less than 110 and DBP [Diastolic BP] less than 60. According to April 2019 Medication Administration Records (MARs), nursing staff documented the resident's BP was out of physician ordered parameters on 04/04/19 (125/59), 04/05/19 (127/48), 04/08/19 (108/56) and 04/18/19 (143/58), and administered the medications. In an interview on 04/24/10 at 11:22 AM, Staff K, Resident Care Manager - RCM, stated nursing staff, definitely should have held the medication as instructed. Failure to follow physician orders, placed the resident at risk for falls related to low blood pressure. According to POs, staff were directed to administer, Milk of Magnesia [MOM] every 24 hours as needed for constipation, Bisacodyl tablet delayed release .give by mouth every 24 hours as needed for constipation, Dulcolax suppository .every 24 hours as needed for constipation not relieved by MOM, Fleet enema insert one .every 24 hours as needed for bowel care if Dulcolax suppository is ineffective. Additional orders were noted on the April 2019 MARs directing staff to administer, Loperamide .give one tablet .as needed for diarrhea and a separate order for, .two table by mouth as needed for diarrhea. In an interview on 04/24/10 at 11:22 PM, Staff K confirmed these bowel orders were unclear as to when to administer which medication, and that nursing staff should have clarified the orders with the physician. (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to April 2019 MARs, nursing staff were directed to monitor for Congestive Heart Failure (CHF) exacerbation, and signs of weight gain or swelling, and nausea. Staff documented a 0, indicating none of these symptoms were present from 04/01/19 through 04/18/19. However, nursing staff documented the administration of Zofran for nausea and vomiting on 04/02/19 at 8:04 PM, and identified a seven pound weight gain from 04/05/19 to 04/08/19. In an interview on 04/24/10 at 11:22 PM, Staff K stated nursing staff should have identified these symptoms and documented them in the MAR, as signs and symptoms of CHF exacerbation. According to April 2019 MARs, nursing staff were directed to, encourage fluids every shift for dehydration. In an interview on 04/24/10 at 11:22 PM, when asked what this meant, Staff K indicated it was, not measurable and the order had, no prompt for staff to document any amount of fluid taken. Staff K indicated this order should have been clarified. Additionally, according to the April 2019 MAR, nursing staff documented that 100 ccs (cubic centimeters) of Intravenous fluids were administered over the course of 24 hours, on 04/04/19 and 04/05/19. In an interview on 04/24/19 at 2:49 PM, Staff B, Director of Nursing, indicated he could only find evidence one bag of IV fluids was provided to the resident. RESIDENT #62 Resident #62 admitted to the facility on [DATE]. According to the 04/23/19 Significant Change MDS, the resident was assessed with diagnoses including heart, kidney and liver disease. This MDS showed the resident required insulin, antibiotics and diuretics on each day of the assessment period. According to April 2019 MARs, staff were directed to administer sliding scale insulin based on blood glucose monitoring three times a day at 9:00 AM, 1:00 PM and 7:00 PM. The POs directed Nursing staff that for blood sugars (BS) over 401, the BS was to be checked in 2 hours, repeat sliding scale. While nursing staff had the potential for repeating the sliding scale BS three times a day, there was no place on the MAR for staff to document any repeat BS testing or subsequent insulin administration. Review of April 2019 MARs revealed the resident was assessed with a BS of 423 on 04/11/19 at 9:00 AM. Nursing staff failed to follow POs and repeat the BS, with required insulin administration, at 11:00 AM. On 04/11/19 at 1:00 PM, staff documented on the MAR a BS of 431. Nursing staff again, failed to perform an additional BS test at 3:00 PM with sliding scale coverage. Similar findings were identified for 04/13/19 at 1:00 PM (BS 412) and 7:00 PM (BS 450) when staff failed to follow POs and repeat sliding scale testing with insulin coverage. Similar findings of no repeat testing were identified on 04/14/19 (BS 495), and 04/19/19 at 1:00 PM (BS 414) and 7:00 PM (BS 451). In an interview on 04/25/19 at 7:51 AM, Staff H, RCM, stated nursing staff should have, but did not follow POs. According to POs dated 04/11/19, nursing staff were to perform, Blood sugar check every 4 hours and were assigned for 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. While nursing staff initialed these tasks were done at the time assigned, review of blood sugar document reports with Staff H, on 04/25/19 at 7:51 AM, revealed nursing staff documented the times these BS were obtained, were not done at the assigned times. (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/13/19, per the MAR, nursing staff documented an, every four hour BS of 278 at 12:00 AM. According to the BS report, staff entered this BS into the computer at 3:55 AM. According to the MAR, the 04/13/19 4:00 AM BS was 349, which was entered into the computer at 4:12 AM. According to the BS report, nursing staff documented a BS of 340 at 8:13 AM, 9:00 AM and 10:48 AM. A BS of 412 was entered at 11:59 AM and 12:01 AM with no subsequent BS documented until 4:56 PM. Similar findings were identified for the every four hour blood sugar documentation on the BS report from 04/11/19 through 04/16/19. In an interview on 04/25/19 at 7:51 AM, Staff H, stated the BS documentation on the BS report was confusing, times documented by nursing staff conflicted with the assigned times, and it was, not likely that the resident would have the exact same BS at 8:13 AM, 9:00 AM and 10:48 AM. Staff H elaborated that nursing staff should have clarified the two orders (sliding scale BS and every four hour BS) to combine the 8:00 AM/ 9:00 AM, 11:00 AM/ 12:00 PM, and 7:00 PM/ 8:00 PM blood sugars In an interview on 04/25/19 at 9:09 AM, Staff C stated that nursing staff, .are supposed to enter [blood sugars] at the time it is done. At this time, Staff B and Staff C confirmed multiple nurses over the course of multiple shifts failed to clarify Resident # 62's PO and administer additional blood sugar testing with administration of insulin as indicated. Review of April 2019 MARs revealed directions, dated 04/10/19, to nursing staff, OK to place peripheral IV and administer 2 amps [ampoules] of D50 (a concentrated sugar solution) one time only for hypoglycemia . Staff JJ, Licensed Nurse, documented that two ampoules were administered. In an interview on 04/25/19 at 11:35 AM, Staff B reported the MAR was wrong and only one ampoule was administered, not two as documented on the MAR. Staff B stated, I gave it (D50) and I only gave one. Staff B subsequently provided documentation to support that only one D50 ampoule was delivered from the pharmacy. Additionally, Staff B reported that Staff JJ, who did not administer the medication, documented that it was administered, stating, He signed it for me. At this time, Staff B confirmed nurses should only document for tasks they completed. Telephone orders dated 04/17/19 directed staff to apply, clear tegaderm dressing over blisters on lower legs, change weekly and if loosened. Apply tubigrip (tubular gauze) from foot to below knees daily while awake. Observations on 04/18/19 at 12:30 PM and 1:20 PM revealed no tegaderm or tubigrip applied to the resident's lower extremities. No tegaderm or tubigrip was noted to the resident's lower extremities on 04/19/19 at 7:45 AM, 11:20 AM or 12:25 PM or on 04/22/19 at 8:10 AM. In an interview with the resident and his significant other, on 04/22/19 at 1:45 PM, both indicated there had been no treatment applied to the resident's lower leg and no application of any type of cloth/tubing to the lower extremities. Record review revealed nursing staff documented the treatment was applied from 04/17/19 through 04/21/19. During an observation on 04/22/19 at 1:51 PM, Staff H confirmed the resident had blisters to the anterior left shin and no treatment was in place (tegaderm or tubigrip). When asked it if looked like tegaderm was ever applied, Staff H stated, no, it doesn't. (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT #20 According to progress notes dated 12/05/18 the resident was referred to, and seen by the facility psychiatrist, who documented, [AGE] year old woman has been depressed she talks about her situation here and the holidays. The psychiatrist documented the resident was on, Cymbalta 30 mg bid [twice a day] and suggested add Abilify 2.5 mg daily as FDA approved adjacent to Cymbalta for depression, keep Cymbalta as is, engage socially as tolerated. Record review revealed no indication facility staff noted, implemented or notified the primary physician of these recommendations. In an interview on 04/23/19 at 11:05 AM Staff G, Social Services, stated, I don't know who referred her [to the psychiatrist], we didn't know she was seen by [psychiatrist], it was probably a floor nurse . Staff G indicated the record should reflect nursing obtained a referral to the psychiatrist, and once recommendations were made, nursing staff should have contacted the primary physician to implement them. In an interview on 04/23/19 at 2:09 PM, Staff I, RCM, indicated the bowel orders for Resident #20 were unclear as both the Bisacodyl and the MOM directed staff to administer each of these medications, every 24 hours as needed. Record review revealed a 04/13/19 PO for Sensodyne proenamel paste 5-0.25 % dentifrices, one application, one time a day for sensitive teeth, while nursing staff documented this treatment was administered on 04/13/19, 04/14/19, 04/15/19, and 04/16/19. However, staff documented a 9 on 04/17/19 and 04/18/19, indicating a referral to progress notes. Progress notes dated 04/17/19 at 2:27 PM indicated, Correction to yesterday's charting Sensodyne toothpaste for sensitive teeth was not administered yesterday, spoke with pharmacy and paste should be delivered tonight. Observation of the pharmacy dispensing label on 04/22/19 revealed the Sensodyne was not received by the the facility until 04/17/19. In an interview on 04/22/19, Staff H stated nurses should not document for treatments that were not administered. Record review revealed POs dated 10/26/18 directing staff to administer, Tylenol Extra strength tablet 500 mg, give 2 tablets by mouth one time a day related to chronic pain, give one tablet QID (four times a day) and 2 tabs at midnight NTE [not to exceed] total of 3,000 mg in (sic) per day. Staff signed this order was implemented once a day each day at midnight. In an interview on 04/22/19, Staff H stated the order was confusing and it should be clarified. According to Pain Consultation records dated 12/26/18 staff were instructed to, Refer to PT [Physical Therapy] TIW [Three times a week] for 12 weeks. Record review revealed no indication facility staff noted this order or implemented the therapy as directed. In an interview on 4/26/19 at 10:11 AM, Staff C confirmed there was no follow up with PT based on the recommendation from the pain clinic stating, We should at least do an eval[uation] to see if she is a candidate . 32898 (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT #19 Record review revealed POs dated 04/16/19 at 8:00 PM, for Erythromycin (antibiotic) Ointment, 5 mg (milligram) for seven days. A review of April 2019 MARs revealed Resident #19 received the initial application on 04/17/19 at 8:00 AM, and the last application on 04/23/19 at 8:00 AM. In an interview on 04/24/19 at 9:37 AM, Staff K was asked if the resident completed the series of antibiotics related to his eye infection. Staff K replied,yes, he should be done with the antibiotics. According to Staff K the series was scheduled to start on 04/16/19 through 04/23/19. In a interview on 04/24/19 at 10:07 AM, Staff C was asked to review Resident #19's Erythromycin POs and the documentation on the April 2019 MAR. Staff C stated that based on the documentation, the resident did not receive the last dose of the antibiotic ointment. RESIDENT#74 During an observation on 04/23/19 at 10:00 AM, Resident #74 was observed lying in bed with white debris in the corners of his lips. The resident's lips were visibly chapped with the skin flaking off. A review of the April 2019 MAR revealed instructions to apply Vaseline to the resident's lips twice daily. In an interview on 04/23/19 at 11:15 AM, Staff GG, Registered Nurse, said, I put Vitamin A&D ointment on his lips. Staff GG was asked if she was sure she applied Vitamin A&D on the resident's lips, she stated yes, and provided a pack of [NAME] Skin Protectant Ointment with Vitamin A&D. Staff GG said, this is the ointment I used for his chapped lips. In an interview on 04/23/19 at 11:24 AM, Staff C stated Vitamin A&D ointment was not a substitute for Vaseline, and shouldn't be used as a substitute without a physician's order. 37044 RESIDENT #31 Record review showed a 11/30/18 PO for Carvedilol (an anti-hypertensive) twice daily every Monday, Wednesday, Friday, and Sunday, directing staff to notify the MD if SBP was greater than 170 or less than 90. Review of the April 2019 MAR showed, Resident #31 had documented SBPs greater than 170 on the following days: 04/01/19 at 8:00 PM (178/94); 04/03/19 at 8:00 AM (189/100); 04/05/19 at 8:00 AM (179/87); 04/05/19 at 8:00 PM (176/71); 04/11/19 at 8:00 PM (178/97); and 04/14/19 at 8:00 PM (171/95). Record review showed no indication the MD was notified as ordered. (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Similar findings were noted for a 11/30/18 PO for Amlodipine (an anti-hypertensive) which directed staff to notify the MD if SBP greater than 170 or less than 90. According to the April 2018 MAR the resident had a BP of 179/97 on 04/05/19 at 8:00 AM. Record review showed no indication the MD was notified as ordered. During an interview 04/22/19 at 11:46 AM when asked if she could find any indication the MD was notified of the SBP greater than 170 as ordered Staff K stated, No. Additionally, during an interview on 04/19/19 at 8:43 AM, Resident #31 stated, I am supposed to have my catheter changed on the first of every month .and it never happened this month. Review of Resident #31's current PO showed, a 12/01/18 order to .Change foley catheter and drainage bag monthly on the first of every month. Review of the April 2019 Treatment Administration Record (TAR) showed that Resident #31 was scheduled to have his catheter changed on 04/01/19. Review of the documentation showed that staff documented N, indicating no it did not occur. Review of the nurses notes gave indication as to why the catheter was not changed as ordered. During an interview on 04/22/19 at 11:28 AM, Staff K explained that it was the expectation that nurses follow physicians' orders, and if unable to, nurses should document why and notify the Physician. When asked why Resident #31's catheter was not changed as ordered Staff K stated, I don't know and acknowledged there was no documentation indicating why the order was not followed or indication the Physician was notified. SIGNING FOR TASKS NOT COMPLETED RESIDENT #31 Observation of Resident #31's toenails on 04/24/19 at 9:41 AM, revealed the right and left great toenails were long untrimmed and curving medially, other toenails were long and untrimmed. When asked if that was how he liked to keep his toenails Resident #31 stated, Hell no, I don't plan on going ice climbing anytime soon. Review of the April 2019 Treatment Administration Record (TAR), showed a 10/26/18 order directing licensed staff to .check fingernails and toenails once per week. This was signed off as completed by Staff P, Licensed Practical Nurse, on 04/12/19 and 04/19/19. In an interview on 04/24/19 at 10:03 AM, Staff P explained that he was signing that he checked the finger and toenails to see if they were long or dirty .if they are trim them, When asked if he trimmed them on 04/19/19, as he had signed, Staff P stated, I did not. When asked if he should sign for tasks he did not complete Staff P stated, No. Review of the April 2019 TAR showed, a 10/25/18 order directing staff to provide Catheter Care every shift LN [licensed nurse] to ensure cath[eter] care completed .Observe for potential complications involving s/s[signs/symptoms] of infection, cath occlusion, cath migration, and skin breakdown at the insertion site . According to the TAR this was being done twice daily. (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/22/19 at 11:16 AM, Resident #31 stated,that catheter care was not done every shift and that the nurses did not observe the insertion site for breakdown. During an interview on 09/24/19 at 10:03 AM when asked how he ensured catheter care was performed Staff P stated, I check whether it [catheter] is in place and urine is flowing. When asked if he checked if the insertion site had been cleansed and that cath care actually was provided Staff P stated, No. When asked if he observed the insertion site for skin breakdown as directed Staff P stated, No. RESIDENT #72 During an interview on 04/18/19 at 11:05 AM, Resident #72 expressed concerns about not receiving her cream for her rash in her [peri area]. Review of the April 2019 TAR revealed, a 04/16/19 order for antifungal cream to be applied to the buttocks and groin for worsening redness for 14 days. Additionally, the was a 04/16/19 order to apply Zinc Paste to buttocks every four hours and as needed. According to the TAR, these treatments had been provided every shift since 04/16/19. Staff P, Licensed Practical Nurse, had signed off as providing these treatments for day shift on 04/17/19, 04/18/19, 04/19/19, 04/24/19, 04/25/19, and 04/26/19. During an interview on 04/26/19 at 9:36 AM, Staff P stated he was familiar with Resident #72 as he was her primary day shift nurse. When asked what treatment he provided for her Staff P stated, [Resident #72] has a treatment to her left leg and gets Nystatin powder under her breasts .she had treatment before to her groin which was Nystatin. When asked if she still had that treatment Staff P stated, No. When asked when the last time he applied the Nystatin cream to Resident #72's groin/buttock, Staff P indicated he could not recall, yet it was signed off as completed daily. Additionally, during an interview on 04/26/19 at 9:36 AM, when asked if Resident #72 received zinc paste to her buttocks every four hours, and as needed, Staff P stated, No, she gets barrier cream. After reviewing the April 2019 TAR, Staff P acknowledged that the resident did have an order for zinc paste and that he had been signing off daily that he applied it every four hours. When asked if he actually had been applying it Staff P stated, No, I have been signing that the CNAs (Certified Nursing Assistants) applied it. When asked if CNAs were allowed to apply Zinc paste Staff P stated, no. OBTAINING CONSULTS RESIDENT #72 A 04/01/19 nurses note stated, Resident returned from [psychiatry] appointment at 11:00 am and writer doesn't [sic]receive any paper work. Message left for RCM to follow up. Record review on 04/23/19 revealed the psychiatry consult still was not in the resident's medical record. During an interview on 04/24/19 at 11:25 AM, Staff I stated, We have not received it yet. When asked who should have called and requested the consult Staff I stated, Nursing. When asked if there was any indication that nursing had attempted to obtain the results of the consult Staff I stated, No and explained we should have it [psychiatry consult] by now. (continued on next page)

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	04/29/2019

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, a 01/11/19 order directed staff to obtain a UA with C&S (Urinalysis with culture and sensitivity.) Record review showed that the UA was obtained on 01/11/19, and the results were received on 01/13/19, but did not include a sensitivity. During an interview on 04/29/19 at 9:18 AM, when asked why a sensitivity was not performed with the urine culture Staff I provided the lab requisition and stated, [staff] only wrote UA [on the lab requisition], acknowledging that the order was transcribed incorrectly. REFERENCE WAC 388-97-1620 (2)(b)(ii) (6)(b)(i).

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	04/29/2019

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32898 Based on observation, interview, and record review the facility failed to provide the necessary care and services to ensure residents' abilities in activities of daily living (ADLs) were maintained for three (#s 45, 72, & 64,) of ten residents reviewed. This failure placed residents at risk for avoidable decline and diminished quality of life. Findings included . 37044 RESIDENT #45 Resident#45 admitted to the facility on [DATE]. According to the 03/07/19 Annual MDS, the resident had functional limitations in range of motion (ROM) to bilateral lower extremities, and received restorative dressing/grooming and active ROM services on six of seven days in the assessment period. According to the .ADL self-care deficit . CP, updated, 04/01/19, staff were directed to provide a Dressing /Grooming Program ADL program: 1. Stand by assist to wash face with wash cloth with tactile and verbal cues. 2. Minimal assistance to comb/brush hair on sides with hand over hand assist with tactile and verbal cues while sitting on wheelchair. Offer program 6 x a week. Review of the restorative flowsheets February 2019 showed the resident was offered/provided her dressing/grooming program only eight of the 24 times she was assessed to require. Similar findings were noted for March 2019 when the program was only offered/provided 13 of 30 times; and April 2019 from 04/01/19 through 01/21/19 the resident was offered/provided the program 11 of 18 times. During an interview on 04/29/19 at 7:51 AM, Staff I, RCM, explained it was the expectation that residents receive their restorative programs at the frequency they were assessed to require. When asked if that occurred for Resident #45 Staff I stated, No. Additionally, according to the 03/07/19 Annual MDS, the resident's preferred language was Vietnamese, the resident needed/wanted a interpreter, and the resident was rarely or never understood. A 04/01/19 .Resident is dependant on staff for meeting emotional, intellectual, physical, and social needs . CP stated, Resident primary language is Vietnamese .Utilize Vietnamese speaking family or language line . A 04/01/19 .Resident has a communication problem CP directed staff to Anticipate and meet needs. Use available staff, family or interpreter as needed for translation .Resident prefers to communicate in Vietnamese. (continued on next page)

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	04/29/2019

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A communication board was observed at Resident #45's bedside that consisted of multiple pictures. The pictures had English subtitles. During an interview on 04/29/19 at 10:41 AM, the English subtitles on the communication board were covered up. Staff I and Staff C, Regional Nurse Consultant, were asked to look a the pictures and explain what they meant, neither was able to do so. When asked if the subtitles should have been in Vietnamese, the Resident's primary language, Staff C stated,Yes. Additionally, when asked if there was any indication that facility staff had used the interpreter line to communicate with the resident Staff C stated, No. RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 Quarterly MDS, the resident had functional limitations in range of motion (ROM) to bilateral lower extremities, and received restorative dressing/grooming and active ROM services on six of seven days in the assessment period. According to the .ADL self-care deficit . CP, updated, 04/01/19, staff were directed to provide a Dressing /Grooming Program ADL program: Brushing teeth/dentures, wash face with wash cloth, combing/brushing hair with set up assistance. Offer program 6 x a week. Review of the Restorative flowsheets February 2019 revealed the residents dressing/grooming program was offered/provided only nine of the 24 times she was assessed to require. Similar findings were noted for March 2019 when the program was only offered/provided 18 of 30 times the resident was assessed to require. During an interview on 04/29/19 at 7:33 AM when asked if Resident #72's dressing and grooming program was being provided at the frequency she was assessed to require Staff I stated, No. RESIDENT #64 Resident #64 admitted to the facility on [DATE]. According to the 03/12/19 Quarterly MDS, the resident had functional limitations in range of motion (ROM) to bilateral lower extremities, and received restorative dressing/grooming services on six of seven days and active ROM services on seven of seven days during the assessment period. According to the .ADL self-care deficit . CP, updated, 12/19/18, staff were directed to provide a Dressing /Grooming Program ADL program: Set up with wash cloth and hair brush/comb, oral care supplies, cue and encourage resident to wash/dry face, do oral rinsing, hair brushing in sitting position in wheel chair, offer stand by assist. Offer program 6 times per week. Review of the Restorative flowsheets February 2019 revealed the residents dressing/grooming program was offered/provided only 11 of the 24 times she was assessed to require. Similar findings were noted for March 2019 when the program was only offered/provided 17 of 30 times, as the resident was assessed to require. During an interview on 04/29/19 at 9:05 AM, Staff K, RCM, explained it was the expectation that resident's receive their restorative programs at the frequency they were assessed to require. When asked if Resident #64 was being provided her restorative program at the frequency she was assessed to require, Staff K stated, No. (continued on next page)

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	04/29/2019

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFERENCE: WAC 388-97-1060 (2)(a)(ii).

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	04/29/2019

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs), for eight (#s 57, 62, 72, 31 3, 33, 34 & 74) of eight sample residents, assessed as dependent on staff, reviewed for ADLs. Failure to provide assistance to residents who were dependent on staff for oral care (#57 & 62), shaving (# 3), nail care (#s 57, 31 & 34), and bathing (#s 72) placed the residents at risk for poor hygiene, soiled long nails, embarrassment and diminished quality of life. Findings included . Refer to: CFR 483.10(f)(1)-(3)(8), F-561, Self Determination CFR 483.12(c)(2)-(4), F-610, Investigate Abuse RESIDENT #57 Resident #57 admitted to the facility on [DATE], and according to the 03/22/19 Admission Minimum Data Set (MDS - an assessment tool), required two person physical assistance with personal hygiene. Observations on 04/19/19 at 9:32 AM revealed, the resident had long fingernails. The resident at that time indicated they were longer than he would like stating, They are due for a trimming. Observation on 04/24/19 08:29 AM with Staff H, Resident Care Manager - RCM, revealed the resident had long nails and wanted them trimmed. The resident stated at that time no one had trimmed, or offered to trim, his nails. According to Staff H, The nurse should be doing [his] nail care, he's diabetic. When asked if it looked like the resident's nails were trimmed, Staff H replied, No it does not. Observations on 04/24/19 at 8:32 AM revealed the resident had missing, broken and what appeared to be carious teeth with white debris noted in the gumline of the existing teeth. In an interview at this time, the resident stated he had his teeth brushed once, When my daughter came, weekend before last. Upon review of the resident's bed side stand, Staff H identified two tooth brushes and two tubes of toothpaste. When asked if it appeared either of the toothbrushes were utilized, Staff H stated, Not recently, the toothbrushes looked new. In an interview on 04/24/19 at 8:39 AM, when asked if it appeared that Resident #57 had been provided oral care, Staff H replied, No. RESIDENT #62 Resident #62 originally admitted to the facility on [DATE], discharged to the hospital on 03/12/19 and readmitted to the facility on [DATE]. The resident was again discharged on [DATE] and readmitted on [DATE]. According to the 4/16/19 5 day MDS, resident #62 was assessed to require extensive two person assistance with bed mobility and dressing, toilet use, and personal hygiene. (continued on next page)

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	04/29/2019

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/19 at 1:27 PM, Resident #62 stated he did not receive assistance with brushing his teeth, stating, I can't get up by myself to go to the BR. Observations at this time revealed the resident had white debris in the gumline of his lower teeth. Similar observations of white debris in the gumline were noted on 04/22/19 before breakfast. In an interview on 04/24/19 at 2:11 PM, when asked about receipt of oral care, Resident #62 stated, I remember they did it once . The resident's family member, at the bed side was asked if she had seen staff offer oral care and stated, No I haven't seen it (oral care). Staff H, present at the time, examined the resident's bedside stand and could not find oral care equipment. When Staff H asked Resident #62 where his toothbrush was, the resident stated, I don't have one. Staff H asked a CNA (Certified Nursing Assistant) where the resident's toothbrush was and the CNA replied, It should be there [bs stand] Staff H searched the resident's room and bathroom and was unable to find any oral care equipment. Staff H, in an interview at 2:22 PM, indicated Resident #62 did not receive the assistance with oral care that he was assessed to require. 32898 RESIDENT #33 According to the 02/19/19 Quarterly MDS, Resident #33 required the extensive assistance of one person with personal hygiene, dressing, toileting and required physical assistance of one person with bathing. On 04/25/19 at 12:09 PM, the resident was observed sitting in his room watching TV. His fingernails were long and untrimmed with a dark brown debris under his finger nails. Resident #33, said, what you looking at. your finger nails, oh, they need cutting .when you gonna come in here and cut em? A review of the resident's ADL's CP dated 03/25/18 revealed, the resident was to scheduled receive assistance with bathing/showers including nail care and assistance with shaving, on Wednesdays. Review of the April 2019 bathing flow sheets revealed Resident #33 received last shower on 04/10/19. No other information provided for shaving and nail care. RESIDENT #74 According to the 03/28/19 Quarterly MDS, Resident #74 was cognitively impaired, required extensive physical assistance of two people with dressing and one person assistance with toileting, physical hygiene and total dependence for bathing. A review of the CP (Care Plan) dated 10/29/18 revealed the resident preferred to have a bath on Mondays and was totally dependent of staff to provide bathing /shower assistance. On 04/18/19 at 1:40 PM, Resident #74 was observed in bed, his hair was tightly curled and uncombed, with dried white debris around his mouth and white crust substance around his eyes. The resident was unshaven with black and gray facial hairs. (continued on next page)

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	04/29/2019

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 04/18/19 at 1:41 PM, Resident #74's son stated, even if they don't get my dad up. I at least want them to get him dressed in comfortable clothing. On 4/19/19 at 1:00 PM, Resident #74 remained unshaved, his hair remained tightly curled and uncombed, and wearing a hospital type gown. In addition, his nails were untrimmed and ragged at the tips. Similar observation was made on 04/23/19 at 11:45 AM. On 04/23/19 at 1:40 PM, Staff K, Resident Care Manager RCM, said, Resident #s 33 & 74 could use a shave and should have their nails trimmed. I'll put a list together and get it taken care of today. During an interview on 04/26/19 at 10:30 AM with the resident's daughter said, I would prefer him dressed in a comfortable shirt, rather than in a hospital gown everyday. RESIDENT #3 According to the 12/25/18 Significant Change MDS(Minimum Data Set-an assessment tool), Resident #3 required two person extensive assistance with bed mobility, dressing, toileting, personal hygiene, and was totally dependent for bathing and shower assistance. A review of 09/08/19 Care Plan (CP) for ADLs (activity of daily living) self-care and performance deficit, revealed the resident was dependent on the physical assistance of one person with bathing/showers weekly on Fridays . On 04/19/19 at 9:15 AM the resident was observed in bed with facial hair that had not been removed. Resident #3 stated, No, they don't help me shave. I used to be able to do it myself, but my razor went missing. On 04/22/19 at 8:50 AM, Resident #3 was observed in bed sleeping. The resident continues to have facial hairs that hadn't been removed. Review of the POC (point of care) Response History report dated 03/29/19 through 04/19/19 staff documented the resident received a bed bath on 03/29/19, 03/30/19, 04/05/19, and a shower on 04/08/19, however, there was no evidence that shaving assistance was provided. 40303 RESIDENT #34 According to the 02/21/19 Admission Minimum Data Set (MDS - an assessment tool), Resident #34 was cognitively intact and required one person physical limited assistance for personal hygiene. Observations on 04/22/19 at 9:31 AM, 04/23/19 at 9:42 AM, 04/24/19 at 10:00 AM, and 04/25/19 at 12:30 PM, showed Resident #34 had long jagged toe nails and fingernails. In an interview on 04/25/19 at 12:32 PM, Resident #34 indicated he had long toe nails stating, The nurses promised to come and cut them but they have not cut them. (continued on next page)

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	04/29/2019

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/19 at 11:40 AM. Staff K, RCM, acknowledged she had promised Resident#34 to trim his toe nails but she was busy and didn't get a chance to go back. When asked who is responsible to trim the resident's toe nails, aff K, indicated nurses and nursing assistant are responsible to do nail care per the care plan. On 04/26/19 at 1:26 PM, Staff B, Director of Nursing, indicated nurses and nursing assistants were responsible to do nail care and empty urinal. Nurse are responsible to ensure the residents are on the barber list for hair cut or shaving. REFERERENC WAC 388-97-1060 (2)(c). 37044 RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 Quarterly Minimum Data Set (MDS, an assessment tool), the resident was understood, able to understand with clear comprehension, had no rejection of care, and was dependent for bathing. During an interview on 04/18/19 at 10:31 AM, Resident #72 expressed she was not being showered frequently enough stating, . one [per week] is not good enough. Resident #72 complained that it made her feel not clean. Review of the facility shower schedule showed Resident #72 was scheduled to receive two showers a week, on Tuesdays and Saturdays. Review of the bathing flowsheets for the last 90 days (01/18/19 to 04/20/19) showed, the resident was not consistently being provided showers two times a week as scheduled. Resident #72 went the following amount of days without showers being offered or provided showers: 01/20/19 -01/29/19 (10 days); 02/03/19-02/08/19 (6 days); 02/24/19-03/01/19 (6 days); 03/03/19-03/14/19 (13 days); and 03/17/19-03/22/19 (6 days). During an interview on 04/29/19 at 7:48 AM, Staff I, RCM, acknowledged that facility staff failed to provide consistent bathing for Resident #72, who was dependent on staff for bathing services. RESIDENT #31 According to the 01/24/19 Quarterly MDS, the resident had a diagnosis of diabetes, and required extensive assistance with personal hygiene. During an interview on 04/19/19 at 8:41 AM, Resident #31 indicated he needed his toenails trimmed stating, They [facility staff] don't do it here .I am supposed to see a podiatrist every six weeks, but he always comes on my dialysis days so I don't get seen. Observation of Resident #31's toenails on 04/24/19 at 9:41 AM, revealed the right and left great toenails were long untrimmed and curving medially, other toenails were long and untrimmed. When asked if that was how he liked to keep his toenails Resident #31 stated, Hell no, I don't plan on going ice climbing anytime soon. (continued on next page)

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	04/29/2019

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the April 2019 Treatment Administration Record (TAR), showed a 10/26/18 order directing licensed staff to .check fingernails and toenails once per week. This was signed off as completed by Staff P on 04/12/19 and 04/19/19. In an interview on 04/24/19 at 10:03 AM, Staff P explained that he was signing that he checked the finger and toenails to see if they were long or dirty .if they are trim them, When asked if he trimmed them on 04/19/19, as he had signed, Staff P stated, I did not. During an observation/interview on 04/24/19 at 2:31 PM, Staff I observed Resident #31's toenails and stated the right and left great toes are overgrown slanting medially .all of them need to be cut .

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	04/29/2019

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 0684 Level of Harm - 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** 20264 Based on observation, interview, and record review, the facility failed to ensure six (#s 20, 57, 49, 62, 69 & 72) of 19 residents reviewed received the necessary care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure two (#s 62 & 57) of three residents reviewed received services related to edema, four (#s 69, 72, 62 & 57) of eight residents reviewed received services related to non-pressure skin issues, and one (# 49) of five residents reviewed received services related to bowel management. These failures placed residents at a risk of decline in medical status and quality of life related to unmet care needs. Additionally, failure to ensure Resident #20 did not receive medically contraindicated medications, in accordance with professional standards of practice, resulted in a severe medical reaction. Findings included . Refer to CFR 483.12(c)(2)-(4), F-610, Investigate Abuse/Neglect RESIDENT #20 Record review showed Resident #20 admitted to the facility on [DATE]. According to the 11/13/18 Quarterly Minimum Data Set (MDS- an assessment tool), the resident had heart disease, diabetes and Multiple Sclerosis (a progressive and painful neuromuscular disease), and required the use of antidepressants and opioid medications on each day of the assessment period. The resident was assessed as cognitively intact, and had no identified hallucinations, delusions, behaviors or refusal of care. Observations on 04/26/19 at 11:50 AM, revealed Resident #20 being transferred from bed to wheelchair via a mechanical lift. In an interview at 12:15 PM, Resident #20 indicated she recalled medication changes which made her, sick a few months past, but did not recall details. According to the December 2018 Medication Administration Records (MARs), Resident #20 received Duloxetine 30 mg (milligrams) twice a day for depression. Review of Pain Clinic notes, dated 12/26/18, showed a recommendation for the resident to start, Tramadol [a medication to treat pain] 50 mg QID [four times a day]. According to the 12/26/18 progress notes, the Tramadol order triggered a drug protocol alert/warning of, The system has identified a possible drug interaction with the following orders: Duloxetine. The alert indicated a possible severe interaction that, may result in the development of Seretonin syndrome (eg. agitation, altered consciousness, ataxia (altered movement), myoclonus (stiffened muscles), overactive reflexes, shivering). According to a 12/26/18 MD communication and order sheet, staff notified the physician that, The system indicates a severe drug interaction of Tramadol and Duloxetine. Kindly address. Staff L, Primary Physician, noted the interaction and directed staff to D/C [discontinue] Duloxetine; [start] Mirtazapine [a different antidepressant], continue Tramadol 50 mg QID as per pain clinic recommendation. (continued on next page)

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	04/29/2019

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 0684 Level of Harm - Actual harm Residents Affected - Few	According to the December 2018 MARs, the Tramadol was initiated and the Duloxetine was discontinued, on the evening of 12/27/18. However, progress notes dated 12/28/18 indicated, Res[ident] refused to take [Mirtazapine] at this shift, Res stated I want to know why they [discontinued] Duloxetine, I am not going to sign the consent Redirected but not successful. Message left to provider. Despite Resident #20 clearly asking why the Duloxetine was discontinued, there was no indication staff informed and/or educated the resident about the risks/benefits of declining the discontinued Duloxetine. A computerized physician prescription, dated 12/28/18, indicated Staff L ordered the Duloxetine to be restarted at 30 mg twice a day, which was implemented on the evening of 12/28/18. According to the December 2018 MAR, the resident received both the Tramadol and Duloxetine starting on 12/28/19. There was no indication facility staff offered alternative care options and/or took steps to minimize any physical decline associated with the identified severe drug interaction, causing a negative outcome, and placing the resident at risk for Serotonin Syndrome. A 12/29/18 note, handwritten by Staff L, indicated, Tramadol contraindicated with Duloxetine. Suggested switching resident to Mirtazapine. She chose to stay on Duloxetine instead of being on Tramadol. There was no indication facility staff clarified with Staff L, based on this note, if the intent was to discontinue the Tramadol, as the Duloxetine was ordered the previous day. There were no progress notes regarding the reinstitution of the Duloxetine, and no indication that staff monitored or evaluated the resident's response to the use of these medications, or considered the potential severe interactions of the concomitant use of the Duloxetine and Tramadol. There was no documentation to support either the physician or facility staff provided education regarding the potential severe interactions with these medications. Record review revealed no risk versus benefit regarding keeping the resident on these contraindicated combination of drugs. In an interview on 04/26/19 at 8:53 AM, Staff C, Nurse Consultant, indicated the clinical record did not provide information to support why the resident was restarted on the Duloxetine, despite clinical contraindication, on 12/28/18. Staff C confirmed staff should have, but did not monitor for the signs and symptoms associated with the contraindication (Serotonin Syndrome). Progress notes dated 01/02/19 indicated, Res[ident] on alert for new pain medication, Tramadol. No [signs symptoms] of sedation noted. Progress notes dated 01/03/19 indicated, Res tolerating dose change of Tramadol without sedation. No c/o pain at this time. The next progress note which addressed either of these medications was dated 01/04/19, showing, New order received, D/C [discontinue] [Duloxetine] at 30 mg, start [Duloxetine] at 20 mg. There was no clinical rationale in the record to support why this change was made. Progress notes reflected the resident experienced a fall on 01/05/19. A nurse's note on 01/06/19 indicated, Resident noted on floor around [3:00 PM] .she thought she is at home, tried to get up from bed, so fell , was also confused . (continued on next page)

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	04/29/2019

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 0684 Level of Harm - Actual harm Residents Affected - Few	A 01/07/19 physician's note written by Staff L, showed, .[Resident #20] presenting for a monthly follow up visit and evaluation for a change in mental status .Staff report confusion and disorientation, accompanied by non-injury slips/falls from WC [wheelchair]. Today, resident dressed only in adult diaper, with blankets pulled to the side, c/o feeling hot, appears drowsy, oriented to person, month and year but not oriented to place, some auditory hallucinations, as she claims to hear her son calling her name out. Limbs appear more rigid. Of note, resident is taking Tramadol 50 mg TID [three times a day] [physician was incorrect-according to the MAR, resident received this medication QID], whilst at the same time on Duloxetine 30 mg qd [each day], despite my having stopped this drug combination by recommending Mirtazapine in place of Duloxetine, to avoid potential for Serotonin syndrome. Bedside blood sugar [BS], 98/mg/dL [milligrams per deciliter] (not eaten all morning), resident BS normally averages above 200 mg/dL. Resident given high energy drink, more alert within minutes, demanding food. Repeat BS 138 mg/dL. Resident can now recognize me as her physician . The 01/07/19 physician note documented a plan of, Resident who had been on Duloxetine 30 mg for depression, started on Tramadol 50 mg TID [physician was incorrect-according to the MAR, resident received this medication QID], for the past week and a half, now exhibiting, confusion, disorientation, increased muscle tone, heat intolerance and slipping out of WC. Is diabetic, was not able to eat leading to low BS. Rebounded somewhat after administration of high calorie drink but not back to baseline, suggested impending and/or evolving Serotonin syndrome as the initial case of CMS [Change in Mental Status]. Plan: d/c Duloxetine. Start Mirtazapine 15 mg [each day] for depression. Monitor vitals. Monitor mental status. Alert OPTUM provider [facility contracted medical provider] notified for any change in mental status, muscle rigidity, seizures, markedly elevated body temperature. Progress notes on 01/07/19 showed, Res alert with confusion, res BS [blood Sugar] 308, 176 and at 2 pm 93, res did not eat anything, deep in sleep, did not take noon medication, OPTUM notified and he saw resident, new order to d/c [Duloxetine] and start Remeron [an antidepressant]. The resident continued to experience changes per a subsequent 01/07/19 progress note of, BS before dinner 80, orange juice 120 ml [milliliters] given .received call from OPTUM notified about BS and held insulin, resident did not take evening meds . Another 01/07/19 6:59 PM progress note indicated, Consent form for Remeron filled but resident not able to sign this time in deep sleep. On 01/08/19 at 5:22 AM staff documented, Resident in bed eyes closed, she has been very drowsy and sleepy. Some narcotics has [sic] been held. Vital signs and blood sugar monitored as she has not been able to eat well . On 01/09/19, staff documented the resident remained, confused. In an interview on 04/25/19 at 12:44 PM, Staff O, Medical Director, indicated a clinical rationale should be documented when changing medications, and in the event of implementing contraindicated medications, a risk benefit analysis should be considered. Staff O indicated that one might have considered discontinuation of the Tramadol. Facility staff failed to implement resident-directed care and treatment consistent with the resident's preferences and professional standards of practice, causing a negative outcome of experiencing identified severe medication interactions. In an interview on 04/26/19 at 8:53 AM, when asked for contact information for Staff L, Staff B indicated Staff L was not returning to the facility. In an interview on 04/26/19 at 11:54 AM, when asked about Staff L's performance, Staff Z, an OPTUM representative, indicated Staff L was asked not to return .he's not coming back. (continued on next page)

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	04/29/2019

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 0684 Level of Harm - Actual harm Residents Affected - Few	NON PRESSURE SKIN ISSUES RESIDENT #57 Record review revealed Resident #57 admitted to the facility on [DATE] and according to the 03/22/19 Admission MDS, had moderate cognitive impairment and required diuretic medications on six of seven days of the assessment period. Observations on 04/19/19 at 9:39 AM revealed, Resident #57 had edema to the right hand, which was noticeably larger than the left hand, and according to the resident, limited the ability to range the fingers on the right hand. The resident reported at this time he had lower extremity edema. Observations on 04/24/19 at 8:45 AM revealed Staff H performed an edema assessment for Resident #57. There were noted indentations in the skin of the left lower leg upon removal of the sock, that did not resolve within four minutes. Similar observations were noted for the right leg. According to Staff H the resident had, edema from toes to knees, that took longer than 20 seconds to rebound. Staff indicated the resident had 2+ edema, the left LE worse than the right. Record review revealed no indication facility staff monitored the resident's edema. In an interview on 04/24/19 at 8:49 AM, Staff H confirmed staff should, but did not, assess or monitor the resident's edema of the lower extremities or the right arm. RESIDENT #69 Resident #69 admitted to the facility on [DATE], and according to the 04/01/19 Admission MDS, had the ability to understand and be understood in conversation, and was at risk for the development of PU, had skin tear/s, and required the application of ointments/medications other than to feet. Observations on 04/19/19 at 8:20 AM revealed Resident #69 had multiple open, bleeding scabs on the face and arms. Similar observations of open bleeding skin lesions were noted on 04/22/19, 04/23/19, 04/24/19 and 04/25/19. According to the weekly skin assessment dated [DATE], the resident was identified with skin that was dry and warm, with scattered scabs over face and arms. The form queried if any of these skin issues were new to which staff responded, no. According to the weekly skin assessment dated [DATE] the resident had dry and warm skin, with no skin issues identified. The weekly skin assessment dated [DATE] identified no open bleeding skin lesions but described the skin as, dry and warm. In an interview on 04/25/19 at 1:14 PM, Staff H, Resident Care Manager, confirmed the resident had open bleeding lesions, and when asked if the weekly skin assessments should reflect the resident's skin issues, replied, yes. RESIDENT #62 Resident #62 admitted to the facility on [DATE] with care needs related to heart, liver and kidney disease, diabetes and respiratory disease. According to the Admission MDS dated [DATE], the resident was assessed as cognitively intact, able to understand and be understood in conversation, and did not require the use of diuretic mediation. (continued on next page)

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	04/29/2019

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 0684 Level of Harm - Actual harm Residents Affected - Few	Observations on 04/18/19 at 1:30 PM, showed a linear area on the left forearm, which was scabbed and other small scattered scabs along the left wrist (three total). There was bruising noted to the right hand and upper arm and anticubital area, and scabs noted on the left foot, second and third toes. The resident's lower extremities were edematous, with multiple small fluid filled blisters on the anterior left lower leg. In an interview at this time, the resident stated that he had lots of edema in both legs. Record review showed the resident had a brief emergency room visit on 04/11/19 and was identified with leg swelling both legs [edema] and marked scrotal edema. Physician notes dated 04/18/19 indicated the resident had, 3+ LE [lower extremity] edema to the feet, including testicles and upper thighs. Record review revealed no indication facility staff were assessing or monitoring the resident's edema. According to progress notes dated 04/21/19, Resident noted with 1.5 x 1 cm skin tear to Lt[left] forearm. noted a dry scab to edge of skin tear. Resident reported he was itch [sic] where old scab is, so he scratched on it and developed a skin tear . Observation on 04/22/19 at 1:20 PM, with Staff H, showed the resident had an island border gauze dressing to the left arm. The resident indicated he admitted to the facility with the left arm injury stating, It's the same skin tear, I just lost the scab .it was dripping blood. Staff H confirmed at this time the resident had 3+ pitting edema up to the thigh, and upon observing the left lower leg stated, it looks like it's going to start weeping, and confirmed the presence of fluid filled blisters. In an interview on 04/22/19 at 1:51 PM, Staff H, Resident Care Manager, indicated staff should have, but did not assess/monitor the resident's non pressure skin issues, including the left forearm, or edema; and once identified did not provide interventions or notification of the physician for the edema. Record review revealed no objective monitoring of the resident's skin lesions (blisters, scabs) or edema. In an interview on 04/22/19 at 1:51 PM, Staff H indicated staff should, but did not, monitor the resident's edema and non pressure skin issues. Staff H stated, We should have a weekly skin observation form [for the left arm wound] done, but we sure didn't. Computerized CNA skin observation documents from 04/13/19 through 04/22/19 revealed that on one shift (04/20/19), staff identified, red area, one staff member, on 04/19/19, identified discoloration and on 04/18/19, one staff identified a skin tear. These skin issues were noted once, and not again by staff on subsequent shifts. In an interview on 04/22/19 at 1:01 PM, Staff H was asked about the CNA skin monitoring section and what it meant. Staff H explained it was the expectation that the aides answer those questions on the form stating, Yes, it's on their task list, if they identify something they should notify their nurse. Staff H indicated each aide on each shift should document any skin issue identified and report it. Upon determining the CNA skin documents did not match observations or nursing documentation, Staff H stated, It's not an effective system . 37044 (continued on next page)

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	04/29/2019

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 0684 Level of Harm - Actual harm Residents Affected - Few	RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 MDS, the resident had one venous ulcer, and required treatment with non-surgical dressing and ointments/medications. Review of the April 2019 Treatment Administration Record (TAR) showed, a 03/15/19 order to cleanse wound to left lower extremity with normal saline, pat dry, cover with bordered foam dressing, and change every Monday, Wednesday, Friday, and as needed. Record review showed, a 03/20/19 Weekly Skin Log [WSL] assessment that indicated the resident had a vascular ulcer to her left anterior lower leg-reopened. According to this assessment, the wound was 3 cm (centimeters) by 1.1 cm by 0.1 cm, the wound base was 100% granulated (Granulation tissue is new connective tissue and microscopic blood vessels that form on the surfaces of a wound during the healing process), and the wound had no drainage. Another WSL was not completed until 04/10/19 (21 days later). According to the 04/10/19 WSL, the vascular ulcer to the left anterior lower leg, now measured 2 cm by 0.5 cm by 0.1 cm, the wound bed was 100% granulated with no drainage. Further record review showed Resident #72 was also being followed by a consulting wound care agency. According to the record, the resident was seen by the consultant on 03/12/19, but not again until 04/10/19. During an interview on 04/29/19 at 9:15 AM, Staff I explained the facility measured and assessed wounds weekly to include, type of wound, location, tissue type, drainage, increasing or decreasing in size, and whether the wound was responding to the current treatment. When asked if there was any indication this occurred for Resident #72, Staff I acknowledged there was no assessment or measurements of Resident #72's left lower extremity wound, for the 21 day period between 03/20/19 and 04/10/19. When asked if failure to assess/measure the wound could detract from staffs' ability to determine if the wound was improving, declining, or responding to the current treatment Staff I stated, Yes . Additionally, a 03/23/19 grievance form was completed by Resident #72's sister on her behalf. The grievance stated, [Resident #72] has a severe rash to her diaper area and this is the 3rd Saturday the aides were saying 'you need some antifungal cream.' Since it has been worse by the week it's apparent there was no fungal (sic) cream applied .Staff P, Licensed Practical Nurse, brought in a tube [of anti-fungal cream] and applied it . The outcome of this grievance stated, [Resident #72] has a small amount of redness {to her groin], Staff P noted it and got an order for fungal (sic) powder. Review of the March 2019 Physician's Orders and TAR revealed no order for an anti-fungal was ever obtained. Nor, was there any direction to staff to assess and monitor the area. During an interview on 04/26/19 at 9:45 AM, Staff I acknowledged staff failed to obtain the treatment order for an anti-fungal, as the resident was assessed to require. When asked if staff were monitoring the rash Staff L stated, It appears we were not. When asked if staff should have been Staff I stated, Absolutely. BOWELS RESIDENT #49 (continued on next page)

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	04/29/2019

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 0684 Level of Harm - Actual harm Residents Affected - Few	According to Physician Orders, staff were directed to administer, Milk of Magnesia [MOM] every 24 hours as needed for constipation, Bisacodyl tablet delayed release .give by mouth every 24 hours as needed for constipation, Dulcolax suppository .every 24 hours as needed for constipation not relieved by MOM, Fleet enema insert one .every 24 hours as needed for bowel care if Dulcolax suppository is ineffective. Review of bowel records revealed Resident #49 went without any bowel movement (BM) from 02/23/19 though 03/01/19. Record review revealed nursing staff failed to administer any of the prescribed bowel medications. In an Reference WAC 388-97-1060 (1) on 04/24/10 at 11:22 PM, Staff K, Resident Care Manager, confirmed nursing staff should have, but did not administer bowel medications, or provide a bowel assessment based on the absence of BMs. REFERENCE: WAC 388-97-1060 (1).

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	04/29/2019

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to ensure residents received proper treatment and assistive devices to maintain vision. Failure to ensure one (#57) of one residents reviewed for vision services, received assistance in obtaining vision devices, placed this resident at risk for decline in Activities of Daily Living (ADLs) related to vision. Findings included . Refer to CFR 483.20(g), F - 641, Accuracy of Assessments RESIDENT #57 According to the 03/22/19 Admission Minimum Data Set (MDS - an assessment tool), the resident admitted to the facility on [DATE], had clear speech, could understand and be understood in conversation, had impaired vision and utilized corrective lenses. In an interview on 04/19/19 at 9:31 AM, Resident #57 was observed lying in bed without his glasses, he stated, I'm blind in one eye, and said he needed glasses and that his were missing. The resident elaborated he never brought his glasses to the facility. According to Care Plan (CP) documents dated 03/25/19, Resident #57 had impaired visual function related to blindness in the left eye. Interventions included, Arrange consultation with eye care practitioner as required. The CP did not identify the resident required the use of glasses for adequate vision. Record review revealed no indication facility staff had made referrals for eye care. In an interview on 04/24/19 10:45 AM, Staff H indicated that she was not aware Resident #57 had glasses, and had not seen any glasses for him. In an interview on 04/24/19 at 10:59 AM, Staff H, Resident Care Manager, stated, I live on this hall and I haven't seen any glasses. Staff H confirmed the, Glasses marked section was answered by staff as not applicable on the personal inventory form dated 03/15/19. In an interview on 04/24/19 at 2:06 PM, Staff H stated that upon further investigation, the resident's daughter took Resident #57's glasses home from the hospital prior to his admission stating, I will call the daughter today to see if she can bring them on the next visit . When asked if staff should have identified the need for glasses before today, Staff H replied, yes. REFERENCE WAC 388-97-1060(3)(a).

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	04/29/2019

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview, and record review, the facility failed to ensure four (#s 45, 72, 34 & 66) of four residents reviewed for limited Range of Motion (ROM), received appropriate treatment and services to increase and/or prevent further decrease in range of motion. This failure placed residents at risk for further decline in ROM. Findings included . RESIDENT #45 Record review revealed Resident#45 admitted to the facility on [DATE]. According to the 03/07/19 Annual Minimum Data Set (MDS - an assessment tool), the resident had functional limitations in range of motion (ROM) to bilateral lower extremities, and received restorative dressing/grooming and active ROM services on six of seven days in the assessment period. A .Resident has limited physical mobility- Restorative Nursing Program care plan (CP), initiated 12/03/17, had a goal of .maintain BUE [bilateral upper extremity] ROM . Staff were directed to provide active ROM to BUE, within functional limits, to all planes of joints for two sets of ten repetitions, six times a week. Review of the Restorative flowsheets for February 2019 showed the resident was only offered/provided her ROM program 13 of the 24 times she was assessed to require. During an interview on 04/29/19 at 7:53 AM, when asked if Resident #45 was being provided her ROM restorative program at the frequency she was assessed to require, Staff I, Resident Care Manager, stated, No. RESIDENT #72 Resident #72 admitted to the facility on [DATE]. According to the 03/22/19 Quarterly MDS, the resident had functional limitations in range of motion (ROM) to bilateral lower extremities, and received restorative dressing/grooming and active ROM services on six of seven days in the assessment period. A .Resident has limited physical mobility CP, initiated 09/15/18, directed staff to provide active ROM to BUE, to all planes of joints, using two pound weights for 3 sets of 10 repetitions, six times a week; and crossing midline reaching exercises, 10 repetitions, while sitting upright on wheelchair, six times a week. Review of the February, March and April 2019 restorative flowsheets revealed the following: From 02/17/19 to 02/27/19 (11 days) the resident was only offered/provided her ROM program one time; from 03/11/19 to 03/17/19 (7 days) the ROM program was only offered/provided one time; 03/23/19 to 03/29/19 (7 days) the resident was offered/provided her ROM program three times; and 04/08/19 to 04/14/19 (7 days) the resident was offered/provided her program three times. (continued on next page)

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	04/29/2019

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/29/19 at 7:34 AM, when asked if Resident #72's ROM program was being provided at the frequency she was assessed to require Staff I stated, No. 40303 RESIDENT#34 According to the 02/21/19 MDS, Resident #34 was cognitively intact and required one person physical limited assistance for personal hygiene. In an interview on 04/24/19 at 1:37 PM, Resident #34 indicated staff did not consistently offer him restorative program. Review of the Resident#34's care plan (CP) revealed the resident had limited physical mobility, and a goal to maintain current level of functioning. Interventions included a Restorative program to maintain strength, balance,Range of motion (ROM) necessary for activity of daily living (ADLs), and to facilitate transfers. Staff were instructed to offer the program six times a week for 15 minutes each day Review of the Restorative Program documentation revealed, Resident #34 did not consistently receive his restorative program six days a week as directed. Restorative flowsheet provided revealed, Resident #34 was not offered restorative program from 03/28/19 to 04/04/19, and from 04/12/19 to 04/14/19. RESIDENT #66 According to the 03/13/19 Admission MDS, Resident #66 was cognitively intact and required one person physical limited assistance for activities of daily living and personal hygiene. On 04/19/19 at 9:20 AM, Resident #66 indicated he did not get restorative therapy since he was transferred to the second floor. The resident further indicated the staff come and walk with him but not every day. when asked how often the staff offers to restorative, Resident #66 stated nce a week. Review of Resident #66's CP revealed the resident had limited physical mobility, goal to maintain current level of functioning. Restorative program to maintain Range of motion (ROM) and strength for bilateral upper extremities. Offer program six times a week for 15 minutes each day. Review of Restorative Program documentation revealed Resident#66 did not receive the restorative programs at the frequency he was assessed to require.Restorative flowsheet provided revealed, Resident #66 was not offered restorative program from 03/14/19 to 03/20/19, 03/23/19 to 03/27/19 and 04/08/19 to 04/11/19. On 04/24/19 at 1:47 PM Staff D, Restorative Director, confirmed the residents did not receive restorative services on the dates indicated on the flow sheet. When asked why the program was not provided, Staff D, indicated sometimes restortaive aides are pulled to work as nursing assistant and the program is not done. REFERENCE: WAC 388-97-1060(3)(d).

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	04/29/2019

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to restore continence to the extent possible, for one (#62) of two residents reviewed for urinary incontinence, and failed to provide catheter care in accordance with professional standards of practice and Physician's Orders, for two (#s 31 & 18) of two residents reviewed with urinary catheters. These failures placed residents at risk for continued decline in urinary function, embarrassment, skin breakdown, and dislodging of urinary catheter. Findings included . RESIDENT #62 Record review revealed Resident #62 admitted to the facility on [DATE] and discharged to the hospital on 3/12/19, returning to the facility on [DATE]. According to the 03/26/19 Admission Minimum Data Set (MDS - an assessment tool) the resident was always continent of bowel and bladder, and required extensive one person physical assistance for toilet use. The resident was discharged to the hospital on 03/30/19 and readmitted to the facility on [DATE]. According to the 04/09/19 Nursing Admission Evaluation, the resident was assessed to require the extensive assistance of one staff for toileting. According to the five day 04/16/19 MDS, Resident #62 now required extensive two person physical assist with toileting, and was always incontinent of urine. Observations on 04/18/19 at 1:33 PM revealed, Resident #62 lying in bed wearing a hospital gown and an incontinent brief. The resident stated he was dependent on the briefs, but before this, he didn't use briefs. In an interview on 04/23/19 at 9:21 AM, Resident #62 stated that he did not have a urinal but he couldn't use it if he had one, because of edema issues stating, .but if someone could hold the urinal for me like they did in the hospital . According to the Kardex (directions to direct care staff for provision of care), printed 04/19/19, the resident was continent of bowel and bladder and required one person extensive assistance for toilet use. Review of Care Plan (CP) documents dated 03/29/19, the resident was identified as at risk for bladder incontinence related to, loss of peritoneal tone with a goal of, will be continent during waking hours through the review date. Interventions indicated, resident is continent. According to the Bowel and Bladder screen dated 04/14/19, Resident #62 was assessed to void appropriately without incontinence, but less than daily. The resident was assessed as able to get to the BR/transfer to toilet/commode/urinal, adjust clothing and wipe, with assistance of 1 person and was usually aware of need to toilet and indicated related conditions were, present, but treatable and under control. This bladder assessment indicated the resident was a candidate for scheduled toileting (timed voiding) but that no toileting program or trial program was currently being used to manage the resident's urinary continence. (continued on next page)

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	04/29/2019

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/19 at 9:40 AM Staff H, Resident Care Manager, reviewed the bladder assessment stating, that [assessment] would prompt you to do a voiding program Staff H indicated staff should have, but did not implement interventions, based on the identified decline in bladder function. Staff H indicated the staff did not address issues that may affect continence (e.g. increased edema (scrotal and penile), and decreased ambulation status. Staff H also acknowledged the 04/14/19 bladder screen did not but should, match the 04/16/19 MDS bladder assessment information. In an interview on 04/23/19 at 1:20 PM, Staff F, MDS Coordinator, listed interventions that she would expect line staff to consider for residents with urinary incontinence, assist with using a urinal, if he is capable of using it .identify if it is due to mobility or cognition, to see what causes the incontinence and then go from there . The CP dated 04/22/19, indicated the resident was incontinent but didn't say why. In an interview on 04/23/19 at 8:57 AM Staff H stated, He was always continent before and was incontinent now, because he was ambulatory before and now he can't get out of bed. Staff H subsequently identified the resident did not, but should, have a urinal. 37044 URINARY CATHETERS RESIDENT #31 According to the 01/31/19 Quarterly MDS, the resident had a diagnosis of neurogenic bladder, and had an indwelling urinary catheter. A .Resident has a catheter: Neurogenic bladder CP, revised 01/30/19, directed staff to, Change catheter monthly . A 12/01/18 Physician Orders (PO) directed staff to, .Change foley catheter and drainage bag monthly on the first of every month. During an interview on 04/19/19 at 8:43 AM, Resident #31 complained, I am supposed to have my catheter changed on the first of every month .and it never happened this month. Review of the April 2019 Treatment Administration Record (TAR) showed that, Resident #31 was scheduled to have his catheter changed on 04/01/19. Review of the documentation showed that staff documented N indicating no it did not occur. Review of the nurses note gave indication as to why the catheter was not changed as ordered. During an interview on 04/22/19 at 11:28 AM Staff K, Resident Care Manager, confirmed Resident #31 had a PO to change his catheter on the first of every month. When asked if that occurred, Staff I stated, No. When asked why Staff I stated, I don't know, and acknowledged there was no documentation to support why the catheter was not changed per PO's. 40303 RESIDENT #18 (continued on next page)

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	04/29/2019

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/29/19 Quarterly MDS, Resident #18 was cognitively intact, and required one person physical limited assistance activity of daily living and personal hygiene. Resident had a chronic suprapubic catheter for urinary retention. Review of Resident #18's CP revised 01/30/19 revealed, Provide catheter care every shift, check for kinks each shift, and keep catheter drainage bag covered with a collection bag at all times to preserve dignity. Keep tubing off the floor and the collection bag below the level of the bladder. Observations on 04/18/19 at 09:31 AM, 04/19/19 at 09:42 AM, 04/22/19 at 10:00 AM, and 04/23/19 at 10:30 AM, showed Resident #18 laying in her bed, with a indwelling suprapubic catheter. The catheter tubing was not secured in place and no privacy bag. In an interview on 04/22/19 at 10:00 AM, Resident #18 revealed she didn't have a catheter strap and did not remember what happened with the one she had. In an interview on 04/26/19 at 11:08 PM, Staff I, Resident Care Manager (RCM) indicated both nurses and nursing assistants are responsible to ensure a catheter leg strap was in place, to avoid accidental dislodgment, kinks, and cover the collection bag with privacy bag for dignity. On 04/26/19 at 1:35 PM Staff B, Director of Nursing, revealed he expected nursing assistants to check and ensure catheter straps and privacy bags were in place, and to notify nurses and RCMs if they are missing. REFERENCE: WAC 388-97-1060 (2)(a)(iii).

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	04/29/2019

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistently with professional standards of practice, for three (#s 69, 49 & 62) of three residents reviewed. The facility failed to provide appropriate treatment and care for intravenous (IV) fluid treatments, including Tunneled, Peripherally Inserted Central Catheters (PICC-specialized intravenous access devices) and peripheral lines as evidenced by: failure to accurately identify the type of IV lines residents had, to ensure physician's flushing orders were based on the type of catheter used, as directed in the facility policy. Nursing staff failed to ensure the record reflected infusion of IV fluids and maintenance as prescribed. These failures placed residents who required IV services, at risk for loss of vascular access and not receiving the correct amount of fluids/medications intended by the physician. Findings included . Refer to CFR 483.21(b)(3)(i), F - 658, Services Provided Meet Professional Standards According to the facility's policy for Central Vascular Access Device Flushing and Locking Policy dated 05/01/16, A physician/licensed independent practitioner order (LIP) is required to flush/lock a catheter (Refer to Appendix A.1, Infusion Maintenance Table. This policy indicated orders should include, Flushing/locking agent(s), strength/concentration, volume, frequency. According to Appendix A.1, there were different flushing instructions depending on the type of IV line. The policy directed as follows: for intermittent use (flushes used in conjunction with administration of medications) of Non-valved lines: Tunneled lines should have 10 mls NS infuse medication then 10 Ml NS followed with 5 mL 10 units /mL heparin. Maintenance flushes (used for lumens not used on a daily basis) for Non-valved Tunneled lines was 10 mls of NS followed by 5 mL of 10 unit/mL heparin. According to the Peripheral Catheter Removal policy dated 05/01/16, staff were directed, upon removal of the catheter, to document date and time, reason for removal length and condition of the catheter, site assessment .action taken if catheter was removed to complications. RESIDENT #69 Resident #69 admitted to the facility on [DATE], and according to the 04/01/19 Admission MDS, received antibiotic therapy, and required the use of Intravenous medications. Observation of the resident on 04/19/19 at 8:15 AM revealed, the resident had a double lumen line to the right chest that was clamped with a clear occlusive dressing. Review of April 2019 MARs revealed, instructions to staff to administer IV antibiotics once daily at 8:00 PM. The order did not contain the type of line through which staff should administer the antibiotics. (continued on next page)

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	04/29/2019

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A separate order on the April 2019 MAR directed staff to administer Sodium Chloride Flush solution .10 mls intravenously every shift for IV line flush . Staff documented the IV flushes twice a day, on day and nightshift. Additionally, there was no use of heparin as directed in the facility policy. Review of POs and MARs revealed there was no separate flush order for the maintenance lumen to ensure patency. Another as needed order directed staff to, Sodium Chloride Flush solution, use 10 ml intravenously as needed for IV line flush, flush IV with 10 ml before and after medication administration. As this was an, as needed order, there were no electronic signatures indicating staff performed the flushes before and after medications. Observations on 04/22/19 at 02:28 PM with Staff H, Resident Care Manager - RCM, revealed the resident had a two lumen line, clamped, with a transparent dressing to the right chest. In an interview at this time, Staff H confirmed it was a, double lumen catheter. When asked what type of line it was, she stated, It's a Midline. When asked how she knew it was a Midline, Staff H replied, It has a 10 ml IV NS flush solution, that's a standard order for a flush. Staff H was unsure if the line was valved or non-valved. Upon further interview, Staff H was unsure about the differences between a PICC and a Midline and a Tunneled catheter, but was clear that it was important to know the difference as each line had a specific flush. Subsequent review, with Staff H, of hospital records dated 03/19/19 revealed Resident #69 had a, right IJ tunneled double-lumen [NAME] catheter. In an interview on 04/22/19 at 2:55 PM, Staff B, Director of Nursing, confirmed the resident admitted to the facility with a tunneled catheter and a flush order from the hospital, which was for Heparin, but that he contacted the provider and had the flush order changed to normal saline, as this was the practice at his previous facility. At this time, Staff B indicated he would have to check to see what the facility policy directed staff to do. According to the facility Infusion Maintenance Table, valved catheters have an integral valve in the catheter therefore requires saline only flushing, while Non-valved catheters require heparin flushing after medication administration, except for short peripheral catheters, which require saline flushes only. In an interview on 04/22/19 at 3:03 PM, Staff AA, Facility Pharmacist, indicated IV orders should include the type of line, as the pharmacy flushing protocol was different depending on its type. In an interview on 04/22/19 at 3:05 PM, Staff C, Nurse Consultant, indicated nursing staff should follow the facility's pharmacy policy for flushing. At this time, Staff C, referred to Staff B to answer the questions regarding following the facility policy for IV flushes. Staff B was asked if there should be separate orders for the two lines, as one was for the intermittent use of medication and the other was not. Staff B later reported facility staff should, but did not, follow the flush protocols for Resident # 69's non valved tunneled line. RESIDENT #49 (continued on next page)

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	04/29/2019

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #49 admitted to the facility on [DATE], and according to the Significant Change MDS dated [DATE], the resident had experienced a decline in condition and now received Hospice Services. Observation on 04/25/19 at 11:19 AM revealed Resident #49 lying in bed, sleeping. No IV was in evidence at this time. According to April 2019 Medication Administration Records (MARs), staff were directed, on 04/04/19, to administer Dextrose -Nacl [sodium chloride) 5-.45 % at the rate of 100 mls (milliliters) per hour intravenously for 24 hours. According to this document, staff signed off that this was implemented. The order did not include the type of line through which the IV fluids should be administered (Peripherally Inserted Venous Catheter - PIV). There was no documentation regarding the location or monitoring of the IV site. There was no indication of who started the IV, how many attempts were made to start the IV, or the size of the catheter used. In an interview on 04/24/19 at 2:49 PM, Staff C, Nurse Consultant, indicated the order should include the type of IV line being utilized. Progress notes dated 04/04/19 at 7:12 PM showed, D5 1/2 NS started (sic) at (2:00 PM) per MD order at 100 ml/hr for 24 hours. Progress notes on 04/05/19 at 1:10 AM showed, IV infusing D5 .45% at 100 cc/hr. IV site clear. Progress notes dated 04/05/19 at 10:26 AM showed, IV fluids will continue for 24 hours from start. Staff did not document when each IV bag (1000 mls each) was started or how much fluid was infused over each shift. While progress notes dated 04/05/19 at 7:53 PM indicated, IV infusion completed. IV site intact. There was no documentation the IV was ever discontinued, who discontinued it, or the condition of the catheter at the time it was discontinued. According to physician orders, the resident required 2400 cc (two full Liter bags and part of a third bag) of fluid over 24 hours. When asked to provide documentation to support the pharmacy provided, or facility staff obtained the three liters of IV fluids (for a total of 2400 mls of fluid), facility staff was only able to provide evidence one liter of IV fluid was supplied by the pharmacy. In an interview on 04/24/19 at 2:49 PM, Staff B, Director of Nursing, confirmed he could find evidence only one bag of IV fluids was provided to the resident. Staff C, at this time, indicated the record should reflect the start time of an IV, it's location, and when the IV ass discontinued, as directed in the policy. RESIDENT #62 Resident #62 admitted to the facility with multiple medically complex diagnoses and according to the 04/16/19 Five Day MDS, required extensive two person assistance for most Activities of Daily Living. Review of the April 2019 MARs revealed directions, dated 04/10/19, to staff, OK to place peripheral IV and administer 2 amps [ampoules] of D50 (a concentrated sugar solution) one time only for hypoglycemia . (continued on next page)

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	04/29/2019

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	While staff documented this IV medication was administered as ordered, there was no documentation to support who started the IV, when it was started, the location or size of catheter used. In an interview on 04/25/19 at 11:25 AM Staff H, Resident Care Manager stated, [Staff B] attempted an IV and couldn't get it, then the IV nurse started it. In an interview on 04/25/19 at 11:35 AM, Staff B stated, I gave the D50, explaining that while the order stated two amps, only one was given. Staff B stated, I clarified the order for just one [amp]. The electronic signature of the person signing for the D50 was not that of Staff B. Staff B elaborated, I just had [another staff member] sign for it . Record review revealed no indication facility staff obtained an order for just one amp of the D50, or clarified the existing instructions which were for two amps. Facility staff was asked to provide information the IV was ever discontinued, who discontinued it, or the condition of the catheter at the time it was discontinued. No information was provided. Record review revealed that on 04/18/19, the primary care provider documented, place peripheral IV line to give albumin 25% IV q 8 hours x 2 days due to low albumin. There were no instructions to maintain the IV line or who started it. Record review revealed no indication of who started the IV, when it was started or the type of line initiated. In an interview on 04/25/19 at 11:42 AM, Staff C indicated that nursing staff should document who starts an IV, when it is started, the location and type of line initiated. Observation on the morning of 04/19/19 revealed, the resident had a peripheral IV (PIV) in the right arm. Observations on 4/22/19 at 1:20 PM with Staff H revealed, the resident had a PIV in the right forearm. Record review revealed no maintenance or monitoring of the IV site took place from 04/20/19 through 04/22/19. Staff H stated nursing staff should have, but did not, obtain orders either to discontinue or to maintain the line for future use. REFERENCE WAC [PHONE NUMBER]60(3)(j)(ii).

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	04/29/2019

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 20264 Based on observation, interview and record review, the facility failed to ensure that three (# 62, 54 & 77) of five residents reviewed for respiratory care, were provided such care, consistent with professional standards of practice. Failure of the facility to ensure Physician Orders for oxygen use, oxygen delivery was provided according to physician ordered flow rates, respiratory status was monitored, and oxygen equipment was maintained according to facility policy, placed residents at risk of discomfort and a potential negative outcome. Findings included . RESIDENT #62 According to the 03/26/19 Admission Minimum Data Set (MDS - an assessment tool), the resident did not utilize oxygen. According to the 04/16/19 Five day MDS, the resident had pulmonary disease and utilized oxygen while a resident. Record review revealed there were no Physician Orders (POs) directing staff to administer, monitor the use of oxygen, or maintain oxygen equipment (clean filters, date/replace oxygen tubing). Observations on 04/18/19, 04/19/19, 04/22/19, 04/23/19 and 04/24/19, showed the resident lying in bed, receiving oxygen through a Nasal Cannula (NC) via oxygen concentrator. Additionally, a continuous positive airway pressure (CPAP) machine was also noted at the bedside. In an interview on 04/23/19 at 9:50 AM, Resident #62 stated he had used the oxygen since he was readmitted to the facility (on 04/09/19). The resident gestured to a CPAP at bedside, and indicated he used it when he first came in, but didn't use it now, pointing to the oxygen tubing stating, I use this. The resident indicated facility staff informed him that use of the oxygen was sufficient, and he didn't have to use the CPAP if he was using the oxygen. According to hospital documents dated 4/09/19, the resident should, continue home PAP [positive air pressure] when sleeping. Review of POs revealed no directions for the use of a CPAP; record review of PO with Staff H, Resident Care Manager - RCM, revealed no mention of a CPAP. In an interview on 04/23/19 at 12:36 PM, after discussing the CPAP being at the bedside, since at least 04/18/19, when asked if staff should have assessed it's use, Staff H replied, Yes. In an interview on 04/23/19 12:36 PM, Resident #62 and his significant other indicated the CPAP at the bedside was his, he used it for his sleep apnea and asthma. At this time the resident indicated someone had told him just to use the oxygen in place of the CPAP. Staff H was requested to provide documentation or a clinical assessment that indicated the resident no longer needed to use the CPAP. No information was provided. (continued on next page)

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	04/29/2019

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress notes dated 04/20/19 at 2:52 AM indicated, Checked his oxygen sat[uration] on room air and it was 92-93(%) but on oxygen it is 98%. There was no mention of flow rate, and no order to support it's use. Progress notes on 04/20/19 at 2:52 AM indicated, He has not wanted to use the CPAP at night just to have the oxygen because he said it is more comfortable. There was no assessment of the resident's use of the CPAP, no directions for it's use, nor did staff question why there were no orders despite the CPAP being at the bedside. When asked, in an interview on 04/23/19 at 12:54 PM, if staff should staff have addressed or clarified the, continue home pap when sleeping directions from the hospital, Staff H replied,Yes. Progress notes dated 04/12/19 indicated the resident, is on oxygen this evening and night and oxygen sat is 96% on 2 Liters. He did not want to use the CPAP just oxygen for tonight. There were no POs which directed staff to utilize oxygen, no assessment by nursing staff which supported the use of oxygen, nor was there any continued consistent assessments regarding the resident's respiratory status with, or without the use of oxygen. 37044 RESIDENT #54 According to the 03/20/19 Quarterly MDS, the resident had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), and required the use of oxygen (O2) therapy. A .Resident has oxygen therapy r/t [related to] COPD . care plan (CP), revised 01/02/19, directed staff to, change O2 tubing, concentrator bottle (if needed) and clean filter every week. Date tubing and bottle when opened .Oxygen nasal cannula: at 2L[iters per minute]/NC with O2 conservation device. Humidified. A review of the April 2019 Physician's Orders (PO) showed, a 10/26/18 order for O2 at 2L via NC continuous. Observations on the following dates revealed: 04/19/19 at 9:10 AM, resident sitting on bed receiving O2 via NC at 3.5 L, no humidifier bottle in place and tubing undated; 04/23/19 at 9:21 AM, resident lying in bed receiving O2 at 3L via NC, no humidifier bottle in place, and tubing undated; and 04/24/19 at 9:15 AM, Resident sitting on bed receiving O2 at 2.5L via NC, no humidifier bottle in place and tubing undated. During an observation on 04/29/19 at 8:37 AM, Staff I, Resident Care Manager, confirmed Resident #54 was receiving O2 at 3L via NC, without a humidifier bottle, and that O2 tubing was undated. During an interview on 04/29/19 at 8:43 AM, when asked if the resident was assessed to require a humidifier bottle Staff I reviewed the CP and stated, Yes and acknowledged one was not in place. When asked if the tubing was dated as directed Staff I stated, No. When asked if the O2 was being administered at 2L via NC as ordered by the physician, Staff I stated, No. 40303 RESIDENT#77 (continued on next page)

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	04/29/2019

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 04/04/19 Quarterly MDS, the resident had a diagnosis of COPD, and required the use of oxygen. On 04/19/19 at 09:49 AM, 04/22/19 at 9:49 AM and 11:02 AM, and 04/23/19 at 10:49 AM, Resident #77 was observed receiving oxygen through a NC delivered via the use of a concentrator machine. The filter on the concentrator was noted to be covered with a heavy layer of dust. On 04/19/19 at 11:11 AM, Resident #77 indicated he used oxygen continuously because he had bad lungs. The oxygen and nebulizer tubing were undated. The resident indicated he was not aware of when his tubing was last changed. On 04/23/19 at 10:49 AM, Staff X, Licensed Nurse, acknowledged the concentrator filter was dirty, and needed to be washed, indicating it was nursing's responsibility to clean the concentrator filters. On 04/24/19 at 12:05 PM, Staff I, RCM, indicated nurses were responsible to change oxygen tubing, and clean concentrator filters once a week and as needed. On 04/26/19 at 1:25 PM, Staff B, Director of Nursing indicated nurses were responsible to change oxygen tubing, and wash concentrator filters once a week, or get new filters from central supply to replace as needed. REFERENCE: WAC 388-97-1060 (3)(j)(vi).

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	04/29/2019

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 20264 Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services, to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments, individual plans of care, and considering the number, acuity and diagnoses of the facility's resident population, in accordance with the facility assessment. Additionally, the facility failed to ensure proficiency of nurse aides. Failure of nursing and nurse aide staff, to demonstrate a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics, that nurses need to perform work roles, or occupational functions, resulted in deficiencies related to the competency of nursing staff, as evidenced by observed medication errors during medication administration. Findings included . F 550 - 483.10(a), Resident Rights Nursing staff failed to ensure care was provided in a dignified manner. F 561- 483.10(f)(1)-(3)(8), Self Determination Nursing staff failed to implement individual plans of care to ensure residents' choices were honored regarding bathing frequency. F 641 - 483.20(g), Accuracy of Assessments Nursing failed to ensure assessments were accurate. F 656 - 483.21(b)(1), Develop/Implement Comprehensive Care Plan Nursing staff failed to ensure care plans were developed and revised as necessary to meet the needs of residents. F 658 - 483.21(b)(3)(ii)(iii), Services Provided Meet Professional Standards Nursing staff failed to ensure facility staff provided care and services according to professional standards of practice. F 676 - 483.24(a)(1)(b)(1)-(5)(i)-(iii), Activities of Daily Living (ADL)/Maintain Abilities Nursing staff failed to provide ambulation services to maintain residents' abilities. F 677 - 483.24(a)(2), ADL Care Provided for Dependent Residents (continued on next page)

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	04/29/2019

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing staff failed to provide ADL care, including showers and nail care to dependent residents. F 684 - 483.25, Quality of Care Nursing staff failed to provided care and services to residents with non-pressure skin issues and medication interactions. F 685 - 483.25(a)(1)(2), Treatment/Devices to Maintain Hearing/Vision. F 688 - 483.25(c)(1)-(3), Increase/Prevent Decrease in ROM/Mobility Nursing staff failed to ensure residents received appropriate treatment and services to increase and/or prevent further decrease in range of motion. F 690 - 483.25(e)(1)-(3), Bowel/Bladder Incontinence, Catheter, UTI Nursing staff failed to identify/assess a decline in urinary incontinence and implement measures to restore urinary function. F 694 - 483.25(h), Parenteral/IV Fluids Nursing staff failed to demonstrate the ability to administer parenteral fluids consistent with professional standards of practice. F 695 - 483.25(i), Respiratory Care Nursing staff failed to ensure residents were provided respiratory care consistent with professional standards of practice. F 757 - 483.45(d)(1)-(6), Drug Regimen is Free From Unnecessary Drugs Nursing failure to adequately monitor and ensure adequate indications for medication use resulted in the use of unnecessary medications. F 758 - 483.45(c)(3)(e)(1)-(5), Free from Unnecessary Psychotropic Meds Nursing failure to adequately monitor and ensure adequate indications for medication use resulted in the use of unnecessary psychotropic medications. F 759 - 483.45(f)(1), Free of Medication Error Rates of 5% or More Nursing staff failed to ensure a medication error rate of less than five percent. F 761 - 483.45(g)(h)(1)(2), Label/Store Drugs & Biologicals Nursing staff did not ensure drugs were stored in accordance with currently accepted principles. (continued on next page)

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	04/29/2019

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, for three (Staff S, T, & U) of four nurses reviewed, facility staff failed to ensure Core Clinical Competencies. In an interview on 04/25/19 at 9:34 AM, Staff V, Staff Development Coordinator, was requested to provide skills competency documents for Staff S, Staff T, and Staff U. Staff V indicated skill competencies should have been, but were not completed for those staff. In an interview on 04/25/19 at 9:16, Staff B, Director of Nursing and Staff C, Corporate Nurse, were asked if, based on the multitude of identified nursing failures including: failure to implement/clarify Physician Orders; track, trend, monitor and assess edema and non pressure skin issues; implement/manage IVs; nursing documenting for care and services not provided, and failure to provide interventions despite notification of a severe drug interactions, facility nurses demonstrated appropriate competency to provide care to meet residents' needs. Staff B replied, No, we need improvement. REFERENCE WAC 388-97-2(b)(i)(ii), (6)(b)(i).

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	04/29/2019

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to provide medically-related social services for four (#s 20, 19, 34, 64, &66) of seven residents reviewed, who demonstrated the behavior of refusals. Failure to identify and seek ways to support residents needs related to refusals, placed residents at risk of unmet care needs. Findings Included . RESIDENT #20 Resident #20 readmitted to the facility on [DATE], and according to the 11/13/18 Quarterly Minimum Data Set (MDS - an assessment tool), was cognitively intact, had no rejection of care. Per the 01/25/19 Significant Change MDS, the resident remained cognitively intact with no behaviors or rejection of care. According to investigative documents dated 11/30/18, the resident was found on the floor in the bathroom at 11:00 AM, in an attempt to self-transfer. Staff documented the resident transfered from bed to electric chair via hoyer (mechanical lift). Staff identified the mechanical lift did not fit in the bathroom and A bedside commode was offered, however, [Resident #20] refused. Record review revealed no indication facility staff attempted to discern the reason for the resident's refusal, or attempted alterative interventions, that might meet the resident's needs. Progress notes dated 01/01/19, indicated the resident refused to check BS [blood sugars] and insulin . Progress notes dated 01/04/19 revealed the, .resident refused medication Avonex [medication to treat Multiple Sclerosis] . Progress notes dated 01/05/19 indicated, Res had a non-injury fall today .Prior to the fall resident had called to use the bathroom and was offered bedpan but refused. Res also refused the Avonex . In an interview on 04/26/19 at 8:53 AM, Staff C, Corporate Nurse, reviewed refusals by Resident #20 stating, We should ask why the resident was refusing, and if continued, notify (the) doctor of whatever it is. We should do education and risk /benefits for this resident .maybe offer psych(iatric) services .it depends on the scenario . When asked if staff should pursue the reason behind the refusals, Staff C stated, Yes. 32898 RESIDENT #19 Review of the April 2019 MAR, showed the resident refused to be weighed on 04/16/19. Review of the April 2019 restorative flowsheets showed, the resident refused to participate in his restorative program on 04/03/19, 04/04/19, 04/18/19, 04/19/19, 04/20/19, 04/24/19 and 04/25/19. Record review showed no indication that staff had identified Resident #19's trendable refusals or attempted to determine the reasons behind refusals. (continued on next page)

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	04/29/2019

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/24/19 at 11:08 AM, Staff K, Resident Care Manager, said she was unaware the resident had been refusing care and services. According to Staff K, the nursing assistants were supposed to notify the nurse assigned to the unit, when residents refused care, and the nurse should document in the progress notes, and notify her, if the resident had a refusal. In an interview on 04/26/19 at 9:50 AM, Staff G, Social Work, said, I wasn't aware the resident had been refusing care. Thus, had not taken any action to determine the reasons behind the refusals. 37044 RESIDENT # 64 According to the 03/12/19 Quarterly MDS, the resident had no behaviors or rejection of care. According to the .ADL self-care deficit . CP, updated, 12/19/18, staff were directed to provide a Dressing /Grooming Program ADL program: Set up with wash cloth and hair brush/comb, oral care supplies, cue and encourage resident to wash/dry face, do oral rinsing, hair brushing in sitting position in wheel chair, offer stand by assist. Offer program 6 times per week. Review of the Restorative documentation for January 2019, showed the resident refused her dressing/grooming program 10 of the 15 times it was offered. Similar findings were noted for February 2019, where staff documented the resident refused her dressing/grooming program seven of 11 times it was offered, and March 2019 where the refused six of 17 times it was offered. Record review revealed no indication that staff identified, or attempted to address, the reasons behind Resident #64's trendable refusals. During an interview on 04/29/19 at 9:14 AM, when asked about social work's role in addressing resident refusals of care, Staff G indicated We (social work) are usually notified of refusals in the morning meeting we talk to the resident and try to get to the bottom of why they are refusing and come up with new interventions. When asked if she was notified of Resident #64's frequent refusals of her dressing/grooming program Staff G stated, No, no one notified me. When asked if she could find any documentation to support the facility identified the refusals and attempted interventions to increase adherence with care Staff G, No .I did not know. During an interview on 04/29/19 at 9:19 AM, when asked if she had identified Resident #64's trendable refusals of her dressing/grooming program Staff D, Restorative Nurse, stated, No, I look at it (restorative programs) during the quarterly period the restorative aides are suppose to tell the nurses. 40303 RESIDENT #66 According to the 03/13/19 Quarterly MDS, Resident #66 was cognitively intact, and had no rejection of care. (continued on next page)

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	04/29/2019

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/19/19 at 10:22 AM, Resident #66 reported he was consistently provided showers. Review of the bathing flowsheets for the last 30 days (03/23/19-04/23/19,showed the resident was offered showers on 10 occasions, but had six documented refusals. Additionally, review of the restorative program documentation from 03/20/19-04/23/19, showed the resident was offered his restorative program eight times and refused on all occasions. Record review revealed no indication staff identified the trendable refusals of care, or attempted to determine the reasons behind the refusals. On 04/23/19 at 12:50 PM, Staff G, Social Services, indicated she was not aware the resident had been refusing care. Thus, had not met with the resident to determine the reasons behind the refusals. On 04/26/19 at 1:35 PM Staff B, Director of Nursing Services - DNS, stated that the RCMs and nurses are responsible to follow up with resident's demonstrating refusals. REFERENCE: WAC 388-97-0960(1).

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	04/29/2019

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to ensure one (#s 20) of five residents reviewed for unnecessary medications, were free from unnecessary drugs, related to the failure to adequately monitor, ensure adequate indications for use, or prevent excessive duration of medication use. These failures placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . Refer to CFR 483.45(c)(i-iii), F-758, Free from Unnec Psychotropic Meds RESIDENT #20 Resident #20 admitted to the facility on [DATE]. According to the 11/13/18 Quarterly Minimum Data Set (MDS- an assessment tool), the resident did not have a diagnosis of depression. According to the 01/25/19 Significant Change MDS, the resident did have a diagnosis of depression. Review of December 2018 Medication Administration Records (MARs), revealed the resident received methylphenidate (Ritalin) 5miligrams (mg) twice a day for ADHD (Attention-deficit/hyperactivity disorder, a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development), Record review showed no indication facility staff identified target behaviors associated with this disorder, or considered the effectiveness of the medication. Although, according to December 2018 MARs, the resident received the Ritalin daily, the 01/15/19 Psychotropic Medication Quarterly Review (PMQR) did not review the use of the Ritalin. According to a 01/18/19 Mental Health Progress Note, Clt(client) requests a higher dose of methylphenidate for the low energy, however based on her complaints of difficulty sleeping and staff observations of paranoia, I do not recommend higher doses. I also did not see any evidence in her chart of an ADHD diagnosis, though clt reports she has been on methylphenidate for many years .with her lack of an ADHD diagnosis, complaints of difficulty sleeping and staff observations of occasional paranoia, I do not support the continued use of methylphenidate. Consider discontinuation of methylphenidate and replace with an activating SSRI (another antidepressant) . Failure to ensure an adequate indication for use detracted from staff's ability to determine if the medication continued to be necessary. According to February 2019 MARS, on 02/19/19, the diagnosis for which the resident received the Ritalin was changed from ADHD to Major Depressive Disorder, Recurrent. In an interview on 04/22/19 at 11:56 AM, when asked why the resident received the Ritalin, Staff I, Resident Care Manager, replied, It's for major depression. When pointed out that the resident received the same medication for ADHD prior to February, and there were no notes with a clinical justification or rationale to change the diagnosis to depression, Staff I stated, It's confusing. (continued on next page)

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	04/29/2019

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 03/28/19 PMQR, staff now reviewed the Ritalin with identified target behaviors being sad affect, negative statements, multiple complains, manipulate, yelling at others, accusatory statements. Staff documented a GDR (Gradual Dose Reduction) was due and was not contraindicated. Staff documented, Reviewed for recommendation of GDR of [sic] patient Ritalin. MD requesting NAVO's recommendation regarding her psychoactive medications. There was no mention of any clinical contraindication for a GDR of the Ritalin or justification why the Mental Health recommendations were not followed. A 04/02/19 PMQR identified TBs of negative statements, multiple complaints, self isolation, verbally abusive as behaviors that required both the use of the Duloxetine and Ritalin. Staff documented the last GDR was 03/28/19 with no further GDR required. Staff documented, MD has recently done a GDR of pt [patient]. At present will continue to monitor. However, review of February through April 2019 MARs revealed no changes to the Ritalin dose, only a diagnosis change on 02/19/19. The resident continued to receive the Ritalin 5 mg twice a day. Failure to ensure accurate psychotropic reviews detracted from staff's ability to track and trend medication changes. In an interview on 04/23/19 at 9:36 AM, Staff C indicated that she believed the Ritalin was being given for sedation/lethargy associated with Multiple Sclerosis, not the depression as documented. Staff C confirmed there was no monitoring of effectiveness, or continued need of use for the Ritalin, and the arbitrary nature of diagnosis change in the absence of clinical justification was confusing. Staff C also stated she was not sure why staff documented on the psychotropic quarterly review that a GDR was done for the Ritalin, because no GDR took place. REFERENCE WAC 388-97-1060 (3)(k)(i).

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	04/29/2019

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20264 Based on interview and record review, the facility failed to ensure four (#s 20, 33, 17 &77) of five residents reviewed for unnecessary medications were free from unnecessary psychotropic drugs related to the failure to: adequately monitor, ensure adequate indications for use, or implement non drug interventions prior to the use of as needed psychotropic medication use. These failures placed residents at risk to receive unnecessary medications and/or adverse side effects. Findings included . Refer to CFR 483.12(C)(2)-(4), F - 610, Investigate Abuse/Neglect 483.20(g), F - 641, Accuracy of Assessments 483.25, F- 684, Quality of Care 483.40(d), F - 745, Provision of Medically Related Social Services RESIDENT #20 According to the 11/13/18 Quarterly Minimum Data Set (MDS - an assessment tool), Resident #20 was assessed to have no psychiatric/mood disorders, require regularly scheduled and as needed pain medication, demonstrate no depression, psychosis, or rejection of care. This MDS showed the resident received antidepressant medication on each day of the assessment period. According to January, 2019, Medication Administration Records (MARs), staff identified the resident required the use of antidepressants related to the following target behaviors (TBs): Verbal (threatening, screaming at others), negative statements, OCD (Obsessive Compulsive Disorder) with care and health, paranoia, manipulative behaviors, accusatory statements, injuring self/others, refusal of hoyer lift, experiencing inconsolable fear, and other, see progress notes. A second set of TBs dated January 2019 identified the following TBs: Anger, Refusing bathes, cussing at staff and other residents, manipulating staff/other residents to get what she wants, refusing BS (blood sugar) checks. Record review showed the resident received Duloxetine (an antidepressant) 30 mgs (milligrams) twice a day. According to the January 2019 MAR, this was reduced to 20 mgs daily, on 01/04/19. Record review revealed no indication why the dose was reduced. When asked, in an interview on 04/25/19 at 1:21 PM, why the dose was changed, Staff C, Corporate Nurse stated, There's no listed reason why .reading the notes, maybe sedation Record review revealed the Duloxetine was discontinued on 01/07/19. However, according to provider notes dated 01/14/19, staff were directed to re-start the Duloxetine, 1 capsule by mouth one time a day for depression Rebound depression [sic]one week after attempted d/c [discontinue] med. (continued on next page)

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	04/29/2019

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the first list of TBs for January 2019 revealed the resident demonstrated no TB between 01/07/19, when the antidepressant was discontinued, and 01/15/19, the day after the medication was reinstated for rebound depression. According to the second set of TBs, the resident demonstrated anger and refusing BS checks on 01/14/19. In an interview on 04/25/19 at 1:21 PM, when asked if there should be documentation to support psychotropic dose changes, Staff B replied, Yes. When asked if such documentation was present for Resident #20, Staff B replied, Not that I can find. Additionally, according to Mental Health Provider notes dated 01/23/19, staff were directed to Please document episodes of tearfulness, anxiety, clt [client] self reports of depression and low mood, as well as the antecedents. This clinician will follow up during next visit. Record review revealed no indication facility staff noted this consult, or implemented the recommended monitoring of depressive behaviors. In an interview on 04/23/19 at 11:08 AM, Staff G, Social Services, stated that facility staff should have implemented monitoring of the depressive behaviors, or documented why it was not done. In an interview on 04/23/19 at 11:08 AM, Staff G, was interviewed about the TBs identified by staff. When asked if, bathing refusals or refusals of blood sugar testing was a TB that required the use of medication, Staff G replied, No. When asked if attempts to get what one wants was a behavior that required medication, Staff G replied, no. When asked if manipulative behaviors could successfully be treated with antidepressant medications, Staff G replied, no. Upon review of the TBs staff identified that required the use of antidepressant treatment, Staff G stated, It looks like the TBs are related to an intolerance of others. Staff G elaborated that staff should inquire regarding the reason behind refusals as the resident could decline a hoyer transfer related to pain. 32898 RESIDENT #33 According to the 02/19/19 Quarterly MDS, Resident #33 was admitted to the facility on [DATE], with care needs associated with DM (diabetes), Renal Disease (kidney) and Non Alzheimer's Dementia. A review of a progress note dated 06/2018, revealed the resident, had a diagnosis of Dementia with Psychosis. The resident was described as alert, calm and having a pleasant mood, not suicidal, but was seeing and picking at things in the air, with poor memory, A review of a Navos (mental health service) Progress note dated 03/28/19, revealed the resident was experiencing visual hallucinations due to chronic kidney disease, Nephrolithiasis (kidney stones) and recurrent UTI (urinary tract infection). In an interview on 04/22/19 at 1:26 PM, Staff K said, in July 2018, he was taking Seroquel 12.5 mg in the morning and 25 mg at night. According to Staff K the resident had a dose reduction in October of 2018. Staff K said, in November 2018, the resident had an infection that was treated with IV(intravenous) antibiotics. Staff K said, we noticed he became more paranoid and began hallucinating after we decreased his Seroquel. (continued on next page)

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	04/29/2019

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Staff K, Staff documented the resident had thrown an IV pole across the room. Staff K was asked if the facility was able to determine if the increase in behaviors were related to the resident's infection or the result of a decrease in the antipsychotic medication. Staff K said, personally, I feel he was in distress related to the decrease in Seroquel. That's when the delusions about vicious dogs and gangsters reemerged. A review of a Psychotropic Medication Quarterly Review, dated 10/17/18 section C, referred to the resident's symptoms and target behaviors, a review of the facility's documentation revealed staff failed to document any symptoms or behaviors the resident may have been experiencing. A review of the resident Care Plan dated 03/15/19, revealed the resident had a history of psychosis and was receiving Seroquel. The resident target symptoms included, paranoia, hallucinations, seeing vicious dogs attacking him, and fear of sleeping in his bed. A review of the behavior documentation revealed no documented behaviors. A review of progress notes revealed no documented behaviors A review of Physician's orders revealed an order dated 02/27/19, for Seroquel (anti-Psychotic)12.5 mg (milligrams). In an interview on 04/22/19 at 9:17 AM Staff K stated, the resident was taking Seroquel for hallucination and episodes of paranoia. In an interview on 04/23/19 at 9:01 AM, Staff K said, I was unable to locate any behavioral documentation indicating the resident experienced negative behaviors. I know that he still occasionally hallucinates and will sit up all night in his wheel chair, so that he can be ready when the gangster and the vicious dogs come. I don't know why staff didn't document the behaviors on the flow sheet more regularly as he was clearly experiencing hallucinations and delusion. Failure to monitor and document the resident's behaviors, placed the resident at risk of not being able to determine the effectiveness of the current treatment, and placed the resident at risk of receiving an unnecessary medication. 40303 RESIDENT #17 According to the 01/24/19 Quarterly MDS, Resident #17 was admitted with a diagnosis of dementia in other diseases classified elsewhere with behavioral disturbance. Review of September 2018 MARs revealed, the resident received Seroquel (antipsychotic medication) one time a day, related to dementia in other diseases classified elsewhere, with behavioral disturbance. According to progress notes dated 12/10/18, the resident's Seroquel dose was increased to twice a day. Record review revealed no clinical rationale, as evidenced by any increase in target behaviors, to support why the Seroquel dose was increased from 12.5 mg every day to 12.5 mg twice a day. Information was requested to support the resident demonstrated increased behaviors, to justify the antipsychotic dose increase. (continued on next page)

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	04/29/2019

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/24/19 at 11:30 AM, Staff K, RCM, indicated, the resident had behaviors, but it looks like the nurses were not documenting the behaviors. Staff K then indicated the expectation was that nurses were to chart target behaviors on the MAR. RESIDENT#77 Review of 04/04/19 Quarterly MDS showed Resident #77 readmitted to the facility on [DATE] with anxiety disorder, depression and manic depression, but no psychotic disorder. This MDS showed the resident received antipsychotic and antidepressant medication on each day of the assessment period. Review of the pharmacy consult report dated 01/07/19 revealed, the resident received Seroquel 100 mg but did not have the indication for use. The consult recommended, The specific diagnosis, indication requiring treatment and a list of symptoms or target behaviors related to the use of the Seroquel. Record review revealed no indication facility staff noted this consult, or implemented the recommended monitoring of symptoms or target behaviors. Review of the anti-psychotic medication informed consent signed 03/29/19, revealed the resident received lithium and Seroquel for major depressive disorder, single episode, unspecified. Review of the physician order dated 04/01/19 revealed the Seroquel was increased to 150 mg at bedtime for increased agitation, irritability, depression. Record review revealed no clinical indication why the Seroquel dose was increased from 100 mg to 150 mg. In an interview on 04/24/19 at 11:30 AM, Staff I RCM, indicated there were no monitoring target behaviors, when asked if there should there be documentation to support psychotropic dose changes, Staff I replied, Yes. In an interview on 04/26/19 at 1:25 PM Staff B, Director of Nursing (DNS) indicated nurses were responsible for monitoring psychotropic medication target behaviors and documenting in the record. Staff B confirmed there were no clinical indications for the resident's dose increase and use. REFERENCE WAC: 388-97-45(c)(3)(e)(1)(2).

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	04/29/2019

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32898 Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than five percent. Failure of one of four nurses (Staff E) to administer medications as prescribed, for two (#s 67, 49) of 11 residents observed during medication pass, resulted in a medication error rate of 8% percent. These failures resulted in the resident receiving the incorrect dose of medication, and placed the residents at risk for negative outcomes. Findings included . RESIDENT #67 On 04/24/19 at 12:05 PM, Staff E entered Resident #67's room and administered oral medication to the resident. Staff E informed the resident that she needed to perform a fasting glucometer to determine if she required insulin before her afternoon meal. According to Staff E, the resident's blood glucose was 449, which required additional insulin. Staff E stated, she . get 30 units of Humalog plus 4 units of the sliding scale. A review of the April 2019 Physcians orders, the resident had a sliding scale order for a blood glucose level of 449, staff was directed to administer 14 units of the sliding scale insulin, for a total of 44 units. Staff E drew 34 units of insulin into the syringe and stated, I'm giving her 30 units plus 4 units of her sliding scale for a total of 34 units. Staff E was asked to verify how much insulin the resident was to receive for a blood sugar of 449, Staff E again stated 30 plus 4 for a total of 34. Staff E entered the resident room, and was heard informing the resident she was going to administer 34 units of insulin. Staff E administered the insulin and returned to the medication cart. Staff E was asked to review and verify the physicians orders. Staff E again stated the resident should have received 34 units of insulin. Staff E was informed according to the sliding scale the resident was to receive 14 units of the sliding scale rather than the 4 units she administered. Staff E replied, I'll just give her an additional 10 units in a little while. RESIDENT#49 On 04/24/19 at 11:47 AM, Staff E was observed preparing medications for Resident #49. Staff E poured liquid medication (Carafate) into a plastic medication cup. A review of the instruction on the medication label read, give 10 ml (milliliter) of Carafate. A visual inspection of the medication cup revealed 9.5 ml of medication was in the cup. Staff E was observed entering the resident's room with the prepared medication on a pink plastic tray. A review of the April 2019 PO's staff was instructed to administer10 mls of Carafate. Staff E was asked to verify the amount of medication in the cup. Staff E drew the medication into a 10 ml syringe and replied, I'm so sorry, it looks like a little bit less than 10 ml. A visual observation of the syringe revealed ,9.5 ml's of medication rather than 10 mls which was ordered by the physician. REFERENCE WAC 388-97-1060 (3)(k)(ii).

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	04/29/2019

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 20264 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled and dated in accordance with currently accepted professional standards, for two of three medication carts reviewed. Additionally, the facility failed to ensure medications were secured for three (# 69, 137, 18) of three residents observed with medications in or around their rooms. The facility failed to secure all medications in a locked storage area and to limit access to authorized personnel. This placed residents at risk to receive expired medications and biologicals. Findings included . RESIDENT #137 Observation on 04/18/19 at 9:50 AM and 1:50 PM, showed Resident #137 in her room sitting on her bed. The resident was noted with a bottle of calcium carbonate at the bedside (bs). The resident indicated she took this medication regularly, when she needed it. Similar observations of the medication at bs were noted on 04/19/18 at 7:55 AM. In an interview on 04/19/19 at 8:23 AM, Staff H, Resident Care Manager, was informed of the medications at bs. Staff H stated, Nope, she shouldn't have those at bedside. They (line staff) should tell her she shouldn't have them at bs and the nurse should take them and lock them up. Staff H elaborated that, There is no reason for her to have to bring them in. They [nursing staff], should get an order if she insists on keeping them . Staff H also indicated that someone should have noticed the medications as they were in plain site. RESIDENT #69 Observations on the morning of 04/23/19 revealed Resident #69 had an inhaler on his overbed table, the box for the inhaler was on the resident's bed. The resident indicated he was short of breath and utilized the inhaler as needed. In an interview on 04/23/19, Staff H indicated staff should be, but were not aware the resident had the inhaler, but would assess the resident's continued need for it's use and ensure it was safely stored. RESIDENT #18 On 04/24/19 at 08:33 AM, Resident #18 was observed with Brimonidine tartrate eye drops on her bedside table. When asked if she is using the medication? The resident stated Yes, but the nurse left it there last night. FACILITY POLICY FOR EXPIRED MEDICATIONS (continued on next page)

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	04/29/2019

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to facility policy for inhaled medications, dated Novemer 2018, Symbacort inhalers should be discarded three months after opening. Xalatan (litanoprost) eye drops, should be dated when opened, stored at room temeprature up to 77 degrees, and discarded after 6 weeks. WEST I MEDICATION CART Observation of the [NAME] I Medication cart, with Staff JJ, Licensed Practical Nurse - LPN, on 04/18/19 09:29 AM, revealed the following: A Symbicort inhaler for Resident #21, with an open date of 11/12/18 (greater than three months past the open date); and Resident #62 had a Symbicort inhaler that was open, but not dated. In an interview at that time Staff JJ indicated the inhalers with stickers of open date should have a date on them, but was unaware how long Symbicort was good for after opening, and would have to refer to the policy. 40303 EAST II MEDICATION CART' On 04/18/19 at 09:17 AM, the East II medication cart was observed with Staff P, Licensed Practical Nurse, observation showed the following: Resident #31 had Dorzolamide eye drops with an open date of 12/16/18, Brimonidine tartrate eye drops opened on 2/11/19, and Litanoprost eye drops that were opened, but undated. Resident #63 had Dorzolamide eye drops with an opened date of 02/14/19, and Brimonidine tartrate eye drops opened on 02/17/19. Resident #11 had Dorzolamide eye drops with an open date of 12/17/18. On 04/26/19 at 11:08 AM Staff I, RCM, indicated all eye drops should be dated when opened and discarded according to pharmacy recommendations. On 04/24/19 at 11:58 AM, Staff AA, Consultant Pharmacist, indicated eye drops can be stored up to six weeks after opening, or depending on the manufacture recommendation. REFERENCE: WAC 388-97-1300(2) and -2340.

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	04/29/2019

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37044 Based on observation, interview and record review, the facility failed to ensure the menu was followed for four (#67, 30, 35 & 4) of 19 residents, whose meals were observed during tray line. Failure to follow renal diet restrictions, and provide accurate portion sizes, placed residents at risk of unmet nutritional needs, and potential negative outcomes. Findings included . On 04/25/19 at 12:12 PM, tray line was observed in the second floor main dining room with Staff LL (Dietary Cook). Observation of the steam table prior to serving revealed, 1/2 cup scoops were present in the potatoes, and collard greens (no other scoop sizes were present) and the flank steak was sliced into 1 oz (ounce) pieces. RENAL DIET According to the menu, residents on renal diets were to be served 2 oz of flank steak, 1/2 cup of rice or noodles, and green beans were to be substituted for collard greens. According to the tray card, Resident #30 was on a renal diet. Staff LL was observed to serve the resident flank steak, noodles, and collard greens. During an interview on 04/25/19 at 12:36 PM, Staff N, Dietary Service Manager, confirmed that Resident #30 should have received green beans instead of collard greens, as directed by the menu. PORTION SIZE According to Staff N, small portion diets were to receive 1/2 regular portions of all items, with regular portion beverages, (no directions were listed on the menu). According to the tray card, Resident #35 was on a small portion diet. Staff LL was observed to serve a full serving size (3 oz) of flank steak (three slices, previously weighed to be 1 oz each), and full serving size of 1/2 cup of potatoes, and collard greens. Similar observations were made for Resident #4, whose tray card directed staff to provide small portions. Staff LL was observed to provide a full serving size of 3 oz of flank steak, and 1/2 cup of potatoes and collard greens. During an interview on 04/25/19 at 12:36 PM Staff N, confirmed that Resident #s 35 and 4 should have, but did not, receive small portions as ordered. According to Staff N, large portions diets were to receive 1 and 1/2 scoops of regular portions, (no directions were listed on the menu). (continued on next page)

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	04/29/2019

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the tray card, Resident #67 was to receive large portions of starch (3/4 cup), and small portions of vegetables (1/4 cup). Staff LL was observed to provide 1/2 cup of both potatoes and collard greens. During an interview on 04/25/19 at 12:36 PM, Staff N acknowledged Resident #67 should have received 3/4 cup of potatoes, and 1/4 cup of collard greens, but did not. REFERENCE WAC 388-97-1100(1).

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	04/29/2019

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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to provide adaptive equipment with meals, for one (#45) of two residents reviewed who required it. Failure to provide adaptive equipment that the resident was assessed to require, placed the resident at risk for decrease meal intake, unmet needs, and diminished quality of life. Findings included . RESIDENT #45 Resident #45 admitted to the facility on [DATE]. According to the 03/07/19 Annual Minimum Data Set (MDS, an assessment tool), the resident was on hospice services for end stage Chronic Obstructive Pulmonary Disease (COPD), required extensive assistance with eating, lost greater than 5% in the past 30 days or 10% in the past 6 months, and was not on a physician prescribed weight loss regimen. Record review showed the following weight trend: 02/21/19 98.9 pounds (#), 03/08/19= 89.8 #; 04/05/19= 81. 8 #; 04/10/19=84.2 #; and 04/11/19= 84 #. This showed the resident had a significant wt loss of greater than 5% in 30 days. According to a 03/08/19 Nutritional Evaluation under Adaptive equipment needed the resident was assessed to require a green two-handled mug w [with]/lid. A .Resident has nutritional problem . care plan (CP), revised 04/17/19, directed staff to: Assist with obtaining special equipment as needed. Rsd [Resident] uses 2 handle mug with lid for drinking fluids; and the resident is on a general pureed texture, thinned to drinkable consistency, nectar thick [NT] liquids [diet] - give puree [food] in two handled cup to drink Observation of Resident #45 for lunch on 04/24/19 at 11:42 AM, showed the resident was served NT milk and water in standard clear plastic cups, without handles or lids. The resident's pureed food was served in a bowl, two burgundy coffee cups, and one blue coffee cup. The coffee cups had one handle and no lids. Review of Resident #45's meal card revealed, there was no direction to staff to provide two handled, lidded cups, as the resident was assessed to require. During an interview on 04/24/19 at 1:02 PM, Staff B, Director of Nursing, acknowledged that Resident #45 was care planned to receive double handled cups with lids. When asked if it was the expectation that the adaptive equipment be provided, as the resident was assessed to require Staff B stated, yes. REFERENCE WAC 388-97-1140 (2).

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	04/29/2019

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 20264 Based on interview and record review, the facility failed to maintain complete, accurate, and readily accessible medical records, for seven (#s 49, 20, 57, 19, 72, 45, & 54) of 21 records reviewed. The facility failed to ensure: physician orders were clear/accurate, bathing & bowel records were clear/accurate, assessment documents accurately reflected resident conditions, informed consents were accurately completed, and resident inventory lists were complete. Failure to ensure clinical records were complete, accurate, and readily accessible, placed residents at risk of not having their needs met. Findings included . Refer to CFR: 483.20(g), F-641, Accuracy of Assessments 483.21(b)(1), F-656, Develop/Implement Comprehensive Care Plan 483.21(b)(3)(ii)(iii), F-658, Services Provided Meet Professional Standards 483.25(h), F-694, Parental/IV fluids 483.70(o)(1)-(4), F-849, Hospice Services RESIDENT #49 Review of Resident #49's April 2019 MARs revealed, nursing staff failed to document the administration of 5:00 PM medications on 04/07/19. During an interview on 04/24/19 at 11:22 AM, Staff K, Resident Care Manager - RCM, stated staff should have made a progress note explaining why the medications were not administered. Review of April 2019 MARs revealed staff documented a 2 for the 7:30 AM and 4:30 PM, insulin administration. In an interview on 04/24/10 at 11:22 PM, Staff K indicated a 2 meant refused, and staff should have, but did not make a progress note explaining why the resident refused, and what interventions were attempted at that time. On 04/05/19, nursing staff documented a 2 for the 7:30 AM insulin, indicating it was refused, but also documented that 2 units of insulin were administered. In an interview on 04/24/10 at 11:22 PM, Staff K indicated the documentation was confusing. According to the April 2019 MARs, the resident had the following bowel care orders: a 10/25/18 order for Bisacodyl 10 mg (milligrams), every 24 hours as needed for constipation; a 10/25/18 order for Miralax 17 grams, every 24 hours, as needed for constipation; and a 10/25/18 order for Milk of Magnesia 30 ml, every 24 hours, as needed for constipation. There was no direction to staff indicating which medication should be used first, or at what point in time. In an interview on 04/24/10 at 11:22 PM, Staff K indicated nursing staff should have clarified the orders. (continued on next page)

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	04/29/2019

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT #20 Record review revealed a PO for staff to inject 14 units of Humalog insulin three times a day before meals. On 04/05/19, nursing staff documented the administration of 199 and 316 units of insulin. On 04/06/19 nursing staff documented the administration of 180, 299 and 214 units of insulin. On 04/07/19, nursing staff documented the administration of 170, 198 and 228 units of insulin. In an interview on the morning of 04/24/19, Staff H, Resident Care Manager, stated that she believed nursing staff mistakenly documented the blood sugar results under the units column. A 04/02/19 Psychotropic Medication Quarterly Review, identified the last Gradual Dose Reduction (GDR) was performed on 03/28/19, with no further GDR required. Staff documented, MD has recently done a GDR of pt [patient] Ritalin. At present will continue to monitor. However, review of February through April 2019 MARs revealed, no changes had been made to the Ritalin order, other than a chnage in dignosis on 02/19/19. The resident continued to receive the Ritalin 5 mg twice a day. Failure to ensure accurate psychotropic reviews, detracted from staff's ability to track and trend medication changes. RESIDENT #57 According to an admission inventory form, dated 03/15/19, the resident had clothing marked but there were no clothing items listed as present. In an interview on 04/24/19 at 10:59 AM, Staff H indicated the inventory information was conflicted. 32898 RESIDENT #19 Record review showed Resident #19 discharged to the hospital on 01/25/19, Return anticipated. In an interview on 04/24/19 at 11:14 AM, Staff Y, stated she was unsure if the resident signed the bed hold policy, as it had not been scanned into the electronic record. According to Staff Y, some of them are kept in a binder, and some are scanned into the electronic record. Staff Y indicated she was unable to find the documentation, and would have to wait until her colleague returned to the facility, to ask if he knew where the document was. RESIDENT #72 03/20/19 and 03/27/19 nurses notes stated Resident #72 was seen by a wound care consultant on those dates. Record review showed, no consults in the resident's record for these reported visits. During an interview on 04/29/19 at 9:15 AM, Staff I, Resident Care Manager, acknowledged there were no wound care consults in the record for 03/20/19 or 03/27/19. A 04/01/19 nurses note stated Resident returned from [psychiatry] appointment at 11:00 am and writer doesn't [sic] receive any paper work. Message left for RCM [Resident Care Manager] to follow up. (continued on next page)

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	04/29/2019

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 04/23/19 showed, the psychiatry consult was still not in Resident #72's record. In an interview on 04/24/19 at 11:25 AM, Staff I, RCM, stated, We have not received it yet. When asked if it should be in the resident's medical record by now (greater than three weeks later) Staff I stated, Yes, we should have it. According to the 09/13/18 Level I PASRR, the resident had diagnoses to include bipolar disorder, and anxiety disorder. A 09/14/18 psychotropic medication consent stated, the resident had schizo (phrenia) and bipolar disorder. During an interview on 04/25/19 at 11:25 AM, when asked if the psychotropic consent was accurate Staff I stated, No and acknowledged Resident #72 did not have a diagnosis of schizophrenia. RESIDENT #45 A 04/17/19 Skin and Weight Assessment stated, Resident is currently on Hospice so weight change is unavoidable r/t [related to] end of life processes . Record review showed the resident was not on hospice services. During an interview on 04/24/19 at 1:02 PM, Staff B, Director of Nursing, confirmed Resident #45 was not on hospice services, and acknowledged the assessment was inaccurate. RESIDENT #54 Review of the April 2019 Medication Administration Record (MAR), showed a 04/16/19 order for Levaquin (an antibiotic), for a URI [upper respiratory infection.] The section of the MAR called Monitors stated Alert charting on ABO [antibiotic] for UTI [urinary tract infection] . During an interview on 04/26/19 at 10:41 AM, when asked if Resident #54 was treated for a UTI or URI Staff B stated, URI and indicated the direction to perform alert charting for a UTI was inaccurate. REFERENCE WAC 388-97-1720(1)(a)(i-iv)(b).

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	04/29/2019

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to develop and maintain a current plan of care in collaboration with hospice, which identified what services were to be provided, and which delineated hospice/facility responsibilities. Additionally, the facility did not have a system by which consistent communication between the facility and hospice staff occurred, for one (#54) of one resident reviewed for hospice services. This failure placed the resident at risk for not receiving necessary care and services. Findings included . According to the [DATE], Skilled Nursing Facility Inpatient Care Services Agreement, Hospice shall establish and maintain a coordinated Plan of Care for each Resident who becomes a patient .The Plan of Care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care .The IDT [Interdisciplinary Team], in conjunction with Nursing Facility representatives and the Nursing Facility Attending Physician, shall review and revise the individualized Plan of Care as frequently as the Resident Patient's condition requires, but no less frequently than every 15 calendar days .Hospice shall provide the Nursing Facility Designee with .a copy of the most recent Plan of Care . RESIDENT #54 Resident #54 admitted to the facility on [DATE]. Record review showed the resident went on hospice services on [DATE], for a diagnosis of end stage chronic obstructive pulmonary disease (COPD). Review of Resident #54's record showed a hospice Interdisciplinary Plan of Care (IPOC) . for the benefit period of [DATE] through [DATE], which expired greater than seven months prior. No current/updated IPOC was present in the resident's record. During an interview on [DATE] at 7:47 AM, when asked what services hospice was providing for Resident #54, Staff I, Resident Care Manager, stated, I think a nurse and a social worker. When asked if the resident had a hospice aide Staff I stated, I don't know, she did in 2018 .I haven't seen one (hospice aide) . and I started in [DATE]. When asked if she should know what services were being provided by hospice Staff I stated, yes. During an interview on [DATE] at 8:21 AM, after reviewing the IPOC, Staff I confirmed the facility did not have a current hospice plan of care. When asked if this contributed to her lack of knowledge of what services Resident #54 was receiving Staff I stated, yes. Staff I then stated communication between hospice and the facility Could definitely be improved upon. REFERENCE WAC [DATE] (1).

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	04/29/2019

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 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** 20264 Based on observation and interview, the facility failed to ensure the use of barriers and/or sanitizing of multi-use equipment between resident use, for five (#'s 44, 84, 49, 67, & 57) 11 residents observed during medication pass. Additionally, facility staff failed to ensure wheelchair armrests were not torn with exposed foam, for two residents (#s 57 & 22), which resulted in an uncleanable surface. These failures placed residents at risk for cross contamination and the spread of microorganisms. Findings included . 32898 RESIDENT #44 On 04/24/19 at 11:33 AM, during medication observation, Staff E (LPN- licensed practical nurse) entered room [ROOM NUMBER] A, where Resident #44 resided. Staff E placed a pink plastic tray, used to transport medications, on the resident's over bed table without the use of a barrier. Staff E applied topical medications, then placed the ointment on the tray, and exited the room. Upon returning to the medication cart, Staff E placed the tray on the cart without sanitizing it. RESIDENT #84 On 04/24/19 at 11:38 AM, Staff E entered Resident #84's room, and placed a plastic tray on the resident's bedside table without the use of a barrier. After administering medications, Staff E exited the room and placed the tray on the medication cart without sanitizing it. RESIDENT #49 On 04/24/19 at 11:58 AM, Staff E was observed placing a plastic tray, used for transporting medications, on the resident's over bed table. After administering the medications, Staff E exited the resident's room and placed the tray on the medication cart without sanitizing it. RESIDENT #67 On 04/24/19 at 12:11 PM, Staff E entered Resident #67's room and placed a plastic tray, used to transport medications, on the resident's over bed table. After administering the resident's medications, Staff E exited the room and placed the tray back on the medication cart without sanitizing it. RESIDENT #57 On 04/29/19 at 9:08 AM, Staff J (RN-registered nurse) was observed preparing medications for Resident #57. Staff J placed the medications on a pink plastic tray and transported them to the first floor dining room, where the resident was seated at a table eating breakfast. (continued on next page)

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	04/29/2019

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff J placed the pink tray on the dining room table in front of the resident, administered the medications, picked up the tray and returned to the medicaiton cart. Staff J then placed the tray on the medication cart without sanitizing it. In an interview on 04/29/19 at 10:00 AM, when asked what the expectation was for sanitizing multi use equipment both Staff B (DNS-director nurse services) and Staff C (RNC- regional nurse consultant), said the expectation was, multi-use items should be sanitized after each use. Uncleanable Surfaces RESIDENT #57 Observations on 04/29/19 at 10:03 AM, showed Resident #57 had a torn left wheelchair armrest with exposed inner foam, making the surface uncleanable. RESIDENT #22 Observation on 04/18/19 at 8:47 AM, showed Resident #22 had torn bilateral armrests on her wheelchair, with exposed foam. In an interview on 04/29/19 at 10:03 AM, Staff C, Regional Nurse Consultant, stated that torn armrest covers were not cleanable surfaces. When asked about the process for identifying needed wheelchair repairs, Staff C stated that maintenance performed monthly wheelchair checks to ensure they were intact. Staff C elaborated that if armrests were torn, nursing staff, or whoever identifies it, is responsible for notifying maintenance via a notebook at the nursing station. REFERENCE WAC 388-97-1320 (1)(c). 40303