



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

June 8, 2016

Mary Ruth Butler, Administrator  
Kindred Nursing & Rehabilitation - Mountain Valley  
601 West Cameron Avenue,  
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

**Congratulations** to both you and your staff on your deficiency-free survey. In today's world with numerous regulations, it is indeed impressive to see a facility functioning as a team at this level.

Continuing to meet the needs of your residents – while recognizing and meeting the administrative needs of your business – is a daily commitment to quality ongoing assessment, care planning and consistent provision of services to each and every client. The greater challenge, of course, is to be able to work as a team to provide this high level of caring and service day after day, week after week, year after year.

Again, **Congratulations** to you and your staff for a job well done, and I challenge you to keep this same high standard in the coming year.

Sincerely,

DEBRA RANSOM, R.N., R.H.I.T.  
Bureau Chief  
DR/dr



DIRK KEMPTHORNE – Governor  
KARL B. KURTZ – Director

IDAHO DEPARTMENT OF  

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June 8, 2016

Mary Ruth Butler, Administrator  
Kindred Nursing & Rehabilitation - Mountain Valley  
601 West Cameron Avenue  
Kellogg, ID 83837-2004

Provider #: 135065

Dear Ms. Butler:

On **May 26, 2016**, a survey was conducted at Kindred Nursing & Rehabilitation - Mountain Valley by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with federal health care requirements regulations during this survey.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing no Medicare and/or Medicaid deficiencies. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom for". The signature is written in a cursive, flowing style.

David Scott, RN, Supervisor  
Long Term Care

Mary Ruth Butler, Administrator  
June 8, 2016  
Page 2

dr/  
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135065</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/26/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION-MOUNTAIN VALLEY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 WEST CAMERON AVENUE KELLOGG, ID 83837</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>Kindred Nursing &amp; Rehabilitation of Mountain Valley is in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The survey team entered the facility on May 23, 2016 and exited on May 26, 2016.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Amy Barclay, RN, BSN Jenny Walker, RN Susan Devereaux, RN</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>06/09/2016</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.