



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

March 31, 2015

Cynthia Riedel, Administrator  
Desert View Care Center of Buhl  
820 Sprague Avenue  
Buhl, ID 83316-1827

Provider #: 135089

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Ms. Riedel:

On **March 19, 2015**, a Facility Fire Safety and Construction survey was conducted at **Desert View Care Center of Buhl** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces

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provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 13, 2015**. Failure to submit an acceptable PoC by **April 13, 2015**, may result in the imposition of civil monetary penalties by **May 2, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **April 23, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 23, 2015**. A change in the seriousness of the deficiencies on **April 23, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 23, 2015**, includes the following:

Denial of payment for new admissions effective **June 19, 2015**.  
42 CFR §488.417(a)

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If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 19, 2015**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 19, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

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BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **April 13, 2015**. If your request for informal dispute resolution is received after **April 13, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Grimes', with a long horizontal line extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

PRINTED: 03/30/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  03/19/2015
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NAME OF PROVIDER OR SUPPLIER  DESERT VIEW CARE CENTER OF BUHL	STREET ADDRESS, CITY, STATE, ZIP CODE 820 SPRAGUE AVENUE BUHL, ID 83316
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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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K 000	INITIAL COMMENTS  The facility is a single story, type V(111) construction with a partial unfinished basement. It has corridor smoke detection and sprinkler coverage and was built in 1958. It has off site monitoring coverage and has 6 exits to grade plus the service exit. The facility is currently licensed for 50 SNF/NF beds.  The following deficiencies were cited during the annual life safety code survey conducted on March 19, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Nathan Elkins Health Facility Surveyor Fire Life Safety & Construction	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

RECEIVED  
APR 13 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia M. Ruedel</i>	TITLE <i>Adm</i>	(X6) DATE <i>4/9/15</i>
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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.

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K 018	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and operational testing it was determined that the facility did not ensure that corridor doors were smoke resisting. Corridor doors that do not resist the passage of smoke can allow smoke and fire gases to enter the corridor in the event of a fire. This deficient practice affected one of three smoke compartments, 21 residents, and staff on the date of survey. The facility is licensed for 50 SNF/NF beds with a census of 45 on the day of survey</p> <p>Finding Include:</p> <p>During the facility tour on March 19, 2015 at approximately 2:30 PM, observation and operational testing revealed the linen closet in the North corridor would not close and latch properly allowing combustible items stored in the linen closet exposed to the corridor. This was observed and noted by the surveyor and the Maintenance Supervisor.</p> <p>Actual NFPA Standard:</p> <p>19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as</p>	K 018		

*Cynthia M. Reckel*

*Adm*

*4/19/15*



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K 021	<p>Continued From page 3</p> <p>b) local smoke detectors designed to detect smoke passing through the opening of a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to ensure doors in stairway enclosures were self-closing. This deficiency can allow smoke and fire to spread rapidly through the facility. This deficient practice affected one of three smoke compartments eight residents and staff members present on the date of survey. The facility is licensed for 50 SNF/NF beds with a census of 45 on the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on March 19, 2015, at approximately 3:00 PM, observation and operational testing revealed the the door leading from the first floor to the basement stairwell was not self closing. Interview with the Maintenance Supervisor revealed the facility was unaware the door was required to self close.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.1.2 A door in a stair enclosure shall be self-closing and shall normally be kept in the closed position. Exception: Doors in stair enclosures held open under the conditions specified by 19.2.2.2.6 and</p>	K 021	<p>The facility will ensure any door in a stairway enclosure will be installed with a self-closer.</p> <p>A spring closer has been installed as of 04-08-2015 to be in compliance with NFPA 19.3.1.2</p> <p>The maintenance supervisor inspected all stair enclosures and assures compliance.</p> <p>The maintenance supervisor will inspect stair enclosures monthly and report to CQI. monthly</p> <p>04/09/15 4/17/15</p>

*Cynthia M. Reedel* 4/19/15  
*Adm*

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K 021	Continued From page 4 19.2.2.2.7.	K 021		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent the safe evacuation of residents during an emergency. This deficient practice affected one of three smoke compartments, eight residents, staff members and visitors present on the day of survey. The facility is licensed for 50 SNF/NF beds with a census of 45 on the day of survey  Findings Include:  During the facility tour on March 19, 2015, between 10:00 AM and 3:30 PM, observation and interview revealed that the west corridor means of egress was obstructed by two wheel chairs and a Hoyer lift. Interview with the Maintenance Supervisor and the Administrator revealed the facility was unaware of that wheeled items were an obstruction to the means of egress.  Actual NFPA Standard:	K 072		

*Cynthia M. Reddie* 4/19/15  
*Adm*

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K 072	Continued From page 5 NFPA 101, 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	<p>The facility will ensure that halls are open to means of egress for safe evacuation of residents during an evacuation.</p> <p>Corridors have been inspected and items removed to comply with NFPA 7.1.10 Means of Egress.</p> <p>The maintenance supervisor will ensure means of egress shall be continuously maintained and free of all obstructions or impediments to full instant use in the case of fire or emergence.</p> <p>Maintenance supervisor will report all education and inspections of halls to CQI. monthly.</p> <p>04/09/15 4/17/15</p>

*Cynthia M. Reedie Adm*

*4/17/15*