



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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DEBBY RANSOM, R.N., R.H.I.T – Chief
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3232 Elder Street
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Boise, Idaho 83720-0009
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PHILIP COPY

September 11, 2015

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

Provider #: 135089

Dear Ms. Riedel:

On **August 28, 2015**, a survey was conducted at Desert View Care Center of Buhl 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 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual 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. If applicable, a similar State Form will be provided 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Cynthia M. Riedel, Administrator
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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 24, 2015**. Failure to submit an acceptable PoC by **September 24, 2015**, may result in the imposition of civil monetary penalties by **October 14, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

A 'per instance' civil money penalty of **\$500.00**.

(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED IN THE STATE OPERATIONS MANUAL §7510) (42 CFR §488.430)

Cynthia M. Riedel, Administrator
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Additional 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 **October 9, 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 **October 9, 2015**. A change in the seriousness of the deficiencies on **October 9, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 9, 2015** includes the following:

Denial of payment for new admissions effective **November 28, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **February 28, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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 **August 28, 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.

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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:

- 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 **September 24, 2015**. If your request for informal dispute resolution is received after **September 24, 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, 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,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj
Enclosures

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

PRINTED: 09/11/2015
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2015
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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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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Kendra Deines, RN, BSN,</p> <p>The survey team entered the facility on August 28, 2015, and exited on August 28, 2015</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CCF = Condition of Change Form CNA = Certified Nurse Aide DM = Dietary Manager DNS = Director of Nursing Services DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NN = Nurses Note PN = Progress Note PRN = As Needed PTO = Physician Telephone Order PU = Pressure Ulcer SAPR = Skin Assessment and Progress Record TAR = Treatment Administration Record WN = Wound Nurse WNN = Wound Nurse Note</p> <p>F 225 SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have</p>	F 000	<p>F225 Investigate/report</p> <p>The facility will thoroughly investigate allegations of neglect. The facility will assure that the violations are thoroughly investigated.</p> <p>The resident that may have been effected by this practice has passed away.</p> <p>All residents are vulnerable and have the potential to be effected by the practice.</p> <p>The facility will continue to educate all staff the F tag regulation relating to investigation of a alleged neglect and the requirements (see exhibit Abuse-A) Snapshot of the abuse policy will be at each nurses station in the abuse policy book (see Exhibit Abuse B)</p> <p>Any report of alleged neglect, will be reported to the administrator , will be called to the 24 hour hot line, and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident and if the alleged violation is verified appropriate corrective action will be taken .</p>	10/9/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia M. Ruedel</i>	TITLE <i>ADMINISTRATOR</i>	(X6) DATE <i>9/24/15</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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F 225	<p>Continued From page 1</p> <p>been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to thoroughly</p>	F 225	<p>F225 Investigate/report Addendum</p> <p>The facility will thoroughly investigate allegations of neglect. The facility will assure that the violations are thoroughly investigated.</p> <p>The systemic failure was a result of investigation within the 24 hours of notification by the ADM and DNS to conclude if abuse definition was met by C N A S that were quarrelling between themselves. Abuse had not occurred.</p> <p>The facility will report all concerns to the 24 hot line , and document thoroughly on our I & A report to Licensure and Certification for review.</p> <p>The exception to this rule will be if discussion occurs between supervisors of L & C and Administrator and deem the allegation would not be under the abuse protocols . This will be documented on the concern.</p>	10/6/15

Cynthia M. Reed

Adm Oct 1, 2015

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

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F 225	<p>Continued From page 2</p> <p>investigate an allegation of neglect for 1 of 11 sampled residents (#11). This failure resulted in a lack of sufficient information being available on which to base corrective action decisions. Findings include:</p> <p>Resident #8 was admitted to the facility 3/25/2003 with multiple diagnoses including syphilitic encephalitis (syphilis infection of the nervous system), muscle weakness, and lack of coordination.</p> <p>The resident's toileting care plan, initiated 1/10/2012, documented the resident was on a dependent toileting program, was always incontinent, and needed 1-2 person assistance with toileting.</p> <p>A letter given to the Administrator and DNS, dated 4/22/15, by CNA #5 documented she witnessed aides, "leaving residents in their own filth for way longer than they should. I heard at least one aide...talk down to a resident..." It continued to document that Resident #11 had feces "everywhere" while CNA #6 & #7 charted, and planned to pass the resident's cares off to the next shift.</p> <p>An undated note by the Administrator documented actions taken upon receiving the letter. These included talking with CNA #6 & #7 about taking immediate action to change residents when soiled, appropriate times to chart, and separated the accused aides from working on the same floor.</p> <p>On 8/27/15 at 5:30 p.m., the Administrator, with the DNS present, were asked about actions taken upon receiving the letter. The DNS stated they</p>	F 225	<ul style="list-style-type: none"> dementia training , on hire, and throughout the year quarterly and Prn on abuse /reporting law The definition of neglect and other forms of abuse . Mandatory all staff in-services will continue to include some form of abuse training, recognition and the reporting law during the quarter . Abuse allegation will be trended reportable or not reportable. A audit will be completed monthly that all reportable are thoroughly reported and investigated <p>All audits will be monitored at the monthly QAPI meeting with Medical Director to ensure the corrective action is effective and that compliance is sustained.</p>	

Cynthia M. Riedel Adm

9-24-15

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F 225	Continued From page 3 had verbally interviewed the aforementioned CNAs and had not documented the interviews. The DNS stated an I&A form was not completed.	F 225	F241 483.15(a) Dignity and Respect of Individuality	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individually. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure an environment to maintain or enhance dignity and respect during their dining experience. This was true for 3 of 7 sampled residents (#s 2, 5 & 6) and any resident who ate their meal in the East Dining Room when they were offered clothing protectors and not offered a cloth napkin. This practice created the potential for harm should residents experience embarrassment or a lack of self-esteem due to their appearance. Findings included: On 8/26/15 at 5:40 PM, during the evening meal observation with 12 residents in the dining room, CNAs were observed to pass out clothing protectors and did not ask if residents they would like to have a cloth napkin. Record review of the care plans for Resident #s 2, 5 and 6, who were present in the dining room on 8/28 at 5:40 PM, did not include the residents preferred clothing protectors.	F 241	Facility will ensure an environment to maintain or enhance dignity and respect during their dining experience. Resident's #2,5,6 the corrective action will be offered the choice of clothing protector, napkin, or both at every meal service. All resident's with the exception of NPO order's of Desert View Care Center have the same potential to be affected and will be offered their choice of clothing protector, napkin, or both. Systemic changes will be adding to new staff orientation that all resident's will be offered the choice of clothing protector, napkin, or both at every meal service. Facility will in-service staff to offer choice of clothing protector, napkin or both at every meal service. EXHIBIT F241#1	10/9/15

Cynthia M. Reed, Administrator

9-24-15

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F 241 F 252 SS=E	<p>Continued From page 4</p> <p>On 8/26/15 at 6:30 PM, CNA #9 stated she knew a lot of the residents liked clothing protectors, but if a resident changed their mind she would get them a cloth napkin.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to create a clean and homelike environment when: *communication cables were exposed in the smoking area and paint was flaking off the building; *an overhang outside the northern/western corridor was water damaged and paint was flaking off the underside; *wall paper was wrinkled and separated in the south hall; and, *the floor was cracked and grout was dirty in the west hall bathroom.</p> <p>This was true for 9 of 11 residents (#1-8 & #10), and any residents, visitors, or staff occupying any of these areas. Findings include:</p> <p>On 8/24/15 at 3:30 p.m., the smoking area for residents was observed. Approximately 20-30 communication cables were strung across the building, gathered near the top of the building above the door to go back into the building. Paint</p>	F 241 F 252	<p>Random audits will be completed on 10 residents to include a combination <i>see exhibit #2</i> of breakfast/lunch/dinner: *Weekly for 4 weeks(10 res) *Bi-weekly for 2 months(10 res) *Monthly for 9 months(10 res) Audits will be increased if trending shows a concern</p> <p>Resident Services will trend audits and review at QAPI monthly with QAPI team and medical director.</p>	10/9/15

Cynthia M. Reedie

Administrator

9/24/15

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F 252	<p>Continued From page 5 was flaking off this wall of the building and the door.</p> <p>On 8/24/15 at 4:00 p.m., a storage area outside the corridor between the north and west halls was observed. The area was visible from the window in the door in the corridor. The overhang outside the window was water damaged and paint was coming off in large portions. Approximately 8 bed frames were observed piled in this area, visible from the corridor window.</p> <p>On 8/25/15 at 9:45 a.m., the south hall wallpaper was coming apart at the seams and was wrinkly.</p> <p>On 8/25/15 at 12:30 p.m., the threshold between the bathroom at the end of the hall and the hallway was cracked and missing pieces. The caulk between the bathroom and shower was dirty and missing pieces.</p> <p>On 8/27/15 at 2:30 p.m., the Maintenance Director was asked about these issues. He stated it would be nice if cables in the smoking area were boxed in and that paint was coming off the door and building. He stated the overhang outside the corridor needed to be removed and that the storage of bed frames looked unpleasant. In the south hallway, he stated the wallpaper was wrinkled by humidity. In the west hall bathroom, he stated the threshold needed to be redone and the shower needed re-caulking.</p>	F 252	<p>F252 Safe/Clean Environment/Homelike Environment Addendum</p> <p>The facility will provide a safe, clean, comfortable and homelike environment.</p> <ul style="list-style-type: none"> • The overhang outside the north and west hall was painted. • Bed frames were removed and disposed of between the north and west hall <p>Maintenance audits Monthly X 1 Year</p> <p>See audit tool (Exhibit 252)</p> <p>Maintenance will review audits and report to QAPI monthly of any concerns not taken care of.</p>
F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores</p>	F 314	

10/6/15

Cynthia M. Riedel Adm

10/1/15

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F 314	<p>Continued From page 6</p> <p>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to provide the necessary nursing care and services to prevent the development and promote healing of a Stage III pressure ulcer (PU). This was true for 1 of 7 (#3) sampled residents. Resident #3 was harmed when she developed a Stage III pressure ulcer to her right heel. Findings included:</p> <p>Resident #3 was admitted to the facility on 3/21/15 with diagnoses which included aftercare for healing traumatic fracture of right hip and generalized muscle weakness.</p> <p>On 3/21/15, the Admit Nursing Assessment and Treatment Administration Record (TAR) documented the resident had a non-blanchable, red right heel, that measured 4.0 cm x 4.5 cm. The area was not documented as open.</p> <p>The 3/21/15 Skin at Risk Care Plan documented the resident was at high risk for skin break down. Interventions included, turn/reposition with 2 staff (no frequency was noted); compression socks/Ted hose; weekly body audit; bath audit every bath/shower day; and report all skin issues to nurse. There were no interventions to address the identified reddened area on the resident's</p>	F 314	<p>F-314 483.25(c) TREATMENT AND SERVICES TO PREVENT/HEAL PRESSURE SORES</p> <p>The facility will ensure that a resident who enters the facility will be provided the necessary nursing care and services to prevent the development and promote healing of pressure ulcers.</p> <p>Resident # 3 will continue to have the WOCN consultant make visits for monitoring and suggesting changes for heel wound. See Exhibit F-314 # 1.</p> <p>Resident #3 care plan was reviewed to include current interventions to address the right heel pressure ulcer; See Exhibit F-314 # 2.</p> <p>Documentation of other environmental factors i.e. wheelchair positioning was completed by Occupational Therapy on multiple dates. See Exhibit F-314 #3</p> <p>Air mattress was ordered 5/12/2015 and will be checked every shift see Exhibit F-314 # 4.</p> <p>10/9/15</p>

Cynthia M. Reed Adm 9/24/15

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F 314	<p>Continued From page 7</p> <p>right heel. The facility did not document an assessment of additional environmental risk factors which may impact the wound, such as positioning in the wheelchair or the addition of an air mattress, to determine if additional interventions might be warranted. A PTO documented to monitor every day and measure every week until healed, and heel protectors while in bed. There was no documentation the heel protectors were used until 3/27/15.</p> <p>On 3/27/15, NNs documented an open area to the resident's right heel, measured 2 cm x 1.5 cm, with serosanguineous fluid present; and that the resident was now wearing heel protectors related to that wound. A PTO documented treatment orders for the area, to monitor every day, measure every week, and notify the physician of any complications. No new care plan interventions were implanted at that time, but the TAR was updated to include the use of heel protectors each shift.</p> <p>On 3/28/15, the Admission MDS Assessment documented the presence of a Stage II PU, with an onset date of 3/26/15. No new care plan interventions for the resident's heel were implemented on 3/28/15.</p> <p>On 3/31/15 skin care plan updates included check the resident's skin weekly and in between for skin issues; wear Sage Boots (a special boot that prevents pressure being exerted to the heel) at all times; reposition every 2 hours while awake, pressure-reduction support to bed and wheelchair, change promptly, ensure good nutrition, pressure wound care as ordered, and extra nutrition due to right heel pressure ulcer. An undated intervention documented the resident</p>	F 314	<p>Additional factors were addressed such as resisting cares and non-compliance and are being tracked each shift. See Exhibit F-314 # 5.</p> <p>Pain will continue to be assessed every shift and with dressing changes. No pain is being reported with dressing changes currently. See exhibit F-314 # 6.</p> <p>Physician notification of wound complications and/or progression of healing will be made monthly and PRN. Physician is made aware of resident #3 wound by physician visit</p> <p>of 9/21/2015. WOCN visit of 9/24/2015 is currently in process of being forwarded to physician for acknowledgment. See Exhibit F-314 # 7.</p> <p>All other residents of the facility with Braden Skin at Risk Assessment score of 6-18 and with additional risk factors are at risk of skin breakdown and will have appropriate skin at risk care plan interventions in place. All residents will have Braden skin at risk assessment audited for additional risk factors and care plans updated as needed, these will be reassessed quarterly and PRN. See Exhibit F-314</p>	

Cynthia M. Ruedif

Administrator 9/24/15

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F 314	<p>Continued From page 8</p> <p>had a right inner heel, Stage III Pressure Ulcer, was seen regularly by a wound nurse, and needed weekly or PRN skin checks. There were no further skin interventions on the resident's care plan.</p> <p>On 4/4/15, a CCF documented there was decline in the right heel wound appearance and condition. The heel was draining serosanguineous fluid, contained an area with large black eschar and measured 3 cm x 3 cm.</p> <p>On 4/7/15, the resident began treatment with a Wound Ostomy Certified Nurse (WN). On that date, a WNN documented the right heel PU, discovered on 3/27, looked like an "old blister" with shallow, denuded edges, was unstageable, had eschar in the center with denuded skin around the wound, measured 5.5 cm x 7 cm with 3 cm x 2 cm eschar.</p> <p>On 4/16/15 a WNN documented the right heel PU had firm eschar in the center, soft edges, dry center, and measured 2.4 x 3 cm. The whole area was tender, wound and eschar were dry in the center and whole eschar was moveable.</p> <p>On 5/2/15, the WNN documented sharp debridement of the right heel PU with 95% of the eschar removed, staged the wound as a Stage III - IV, and would likely require debridement in 1-2 weeks.</p> <p>On 5/6/15, a SAPR documented the wound measured 2.7 x 3.0 cm; had copious amounts of thick/thin, yellow/clear drainage; cream colored slough in center with purple/burgundy border to upper outer edges; strong odor; no tunneling; Stage III; painful; WN notified and would look at</p>	F 314	<p># 8</p> <p>The facility will include the addition of double check system with two nurse signatures to verify that Braden Skin at Risk Assessment and other risk factors are completed and interventions have been implemented at admission to the facility. See Exhibit F-314 # 9.</p> <p>The facility will include the addition of a TAR form that includes common interventions for skin breakdown prevention for licensed nurse to utilize on admission for interventions in place. See Exhibit F-314 # 10</p> <p>Licensed nurse will sign off on turn reposition sheets every shift when completed by aides to ensure supervision of interventions being completed. See Exhibit F-314 # 11.</p> <p>The facility will monitor performance to ensure the corrective actions are effective and compliant by auditing:</p> <p>All new admissions to the facility will be audited for completion of printed</p>	

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F 314	<p>Continued From page 9 wound on 5/7.</p> <p>On 5/7/15, the WNN documented the wound bed was yellow except for a small area of 0.5 diameter in the upper center of the wound which was deep red. The wound was debrided, and had bruising at the upper mid-edge, which was the possible source of the PU, and measured 0.2 x 1.3 cm. When the wound was cleansed, a small slough filled area adjacent to the main wound was documented at the 8 o'clock position and measured 1 x 0.2 cm. The note documented concern of additional pressure risk from the resident's wheelchair. The WNN documented to continue to protect the heel with the Sage boot and suggested the facility have PT evaluate the resident's wheelchair for further pressure protection. The facility did not provide documentation the wheelchair was evaluated.</p> <p>On 5/12/15, a CCF was sent to the resident's physician requesting a pressure relieving air mattress, which was ordered at that time.</p> <p>On 5/30/15, an SAPR documented the Stage III wound measured 3 cm x 2.5 cm; 0 depth; had a moderate amount of cream drainage; was cream colored with pink edges, had no odor or tunneling; and was covered in slough.</p> <p>On 6/3/15, a WNN documented the wound was sharply debrided, measured 3 cm x 2.5 cm x 0.2 cm depth, and had mild undermining edges with mild odor prior to cleansing and debridement.</p> <p>On 6/10/15, a WNN documented conservative sharp debridement of slough performed with complaints of mild pain, measured 2.5 x 2.7 x 0.3 cm, had no odor, small amount of drainage.</p>	F 314	

TAR skin interventions. Trending of audits will be reported to QAPI team/medical director monthly.

Nurse Licensed Double check system will be audited following all new admissions. Trending of audits will be reported to QAPI team/medical director monthly.

Braden scale intervention and additional risk factors sheet will be audited for completion with all new admissions. Trending of audits will be reported to QAPI team/medical director monthly.

Turn and reposition sheets will be audited for all residents with existing pressure ulcers and for those who may be admitted with or develop.

Wound documentation
Month change over carried through
Pain following dressing changes
Wheel chair cushions in place
All residents with reported red areas over bony prominences and those residents with existing pressure ulcers:

- Weekly x four weeks.
- Then bi-weekly x 2 months then
- Monthly x 9 months. Auditing and education will increase in frequency if needed until compliance is maintained.

Trending of audits will be reported to QAPI team/medical director monthly.

Cynthia M. Reedif Adm

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F 314	<p>Continued From page 10</p> <p>On 6/25/15, an SAPR documented no changes in the wound measurements, with a small amount of yellow/pink drainage. The wound had white/red edges with pink and cream lumps in the center; and was painful. Wound measurements were not documented again until 7/4/15.</p> <p>On 7/6/15, a SAPR documented the was painful.</p> <p>On 7/15/15, a SAPR documented the wound measured 2.1 cm x 1.9 cm x 0.3 cm, and was painful.</p> <p>On 7/25/15, the TAR documented the wound was 2.0 x 2.0 x 0.2 cm. On 7/31/15, a SAPR documented the wound measured 2.2 cm x 2.4 cm x 0.2 cm and was painful;</p> <p>On 8/5/15, the WNN documented the resident complained of pain when edges on heel wound were touched.</p> <p>On 8/11/15, the SAPR documented the wound measured 1.8 cm x 1.9 cm x 0.2 cm and was painful.</p> <p>On 8/17/15, a SAPR documented the wound measured 1.9 cm x 1.5 cm x 0.2 cm and was painful. The form documented the physician would be notified of "complications," but documentation of that notification, or the results of the physician's assessment, were not provided and no new orders were noted.</p> <p>On 8/24/15 a SPAR documented the wound measured 1.5 cm x 1.1 cm x 0.2 cm and was painful.</p>	F 314	<p>EXHIBIT F-314 # 1 COPY OF WOCN CONSULTANT NOTE 9/24/2015</p> <p>EXHIBIT F-314 # 2 COPY OF CARE PLAN FOR WOUND HEALING</p> <p>EXHIBIT F-314 # 3 COPY OF WHEELCHAIR ASSESSMENT</p> <p>EXHIBIT F-314 # 4 COPY OF AIR MATTRESS ORDER OF 5/12/2015 AND COPY OF TAR AIR MATTRESS CHECKS FOR SEPTEMBER</p> <p>EXHIBIT F-314 # 5 COPY OF RESISTS CARES AND NONCOMPLIANCE FOR MONTH OF SEPTEMBER</p> <p>EXHIBIT F-314 # 6 COPY OF PAIN ASSESSMENT WITH DRESSING CHANGES FOR SEPTEMBER</p> <p>EXHIBIT F-314 # 7 COPY OF PHYSICIAN VISIT 9/21/2015 DOCUMENTATION ADDRESSING RIGHT HEEL PRESSURE ULCER.</p> <p>EXHIBIT F-314 # 8 COPY OF LICENSED NURSE IN-SERVICE FOR UPDATED BRADEN SKIN AT RISK ASSESSMENT WITH ADDITIONAL RISK FACTORS</p> <p>EXHIBIT F-314 # 9 COPY OF DOUBLE CHECK SYSTEM</p> <p>EXHIBIT F-314 # 10 COPY OF TAR FOR WOUND CARE</p> <p>EXHIBIT F-314 # 11 COPY OF TURN/REPOSITION CHARTING WITH LICENSED NURSE SIGNATURE</p>	

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F 314	<p>Continued From page 11</p> <p>On 8/25/15, LN #8 stated the WN first saw the resident on 4/7/15 and was not able to debride the wound at that time. The LN stated the facility had not consistently documented the wound characteristics.</p> <p>On 8/27/15, LN #8 stated the wound started as a Stage I and more preventative measures should have been done on admission, like adding Sage Boots, to prevent the progression of the wound. LN #8 stated the wound progressed to unstageable and the WN was called on 4/7 to help with treatment.</p> <p>On 8/27/15 at 3:30 PM, Resident #3's right heel PU was observed with LN #8 who measured the wound at 2 cm L x 1.3 cm W x 0.3 cm D.</p> <p>Resident #3 was harmed when an Unstageable PU was allowed to develop due to the facility's failure to ensure the residents heels were elevated or order Sage Boots on admission when the resident was assessed to have a red, non-blanchable right heel. The facility did not document environmental factors, such as wheelchair positioning or the use of an air mattress, were evaluated for PU risk, nor that Sage Boots were consistently applied after they had been implemented as an intervention. On 3/27/15, an open area to the right heel was first documented as a Stage II PU, and later assessed by the WN as a Stage III - IV. Resident #3's Skin Care Plan did not include pressure ulcer preventive measures for a resident who had a non-blanchable, red, right heel prior to 3/31/15. There was inconsistent documentation of the characteristics of the wound. In addition, the facility failed to have the wound assessed by the WN until after the PU had progressed to an</p>	F 314			

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F 314 F 328 SS=D	Continued From page 12 Unstageable PU. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to administer oxygen as ordered for 1 of 11 sampled residents (Resident #10) when the oxygen liter flow rate was incorrect and the resident did not receive continuous oxygen during meals. The failure created the potential for the resident to experience breathing problems when respiratory needs were not met. Findings include: Resident #10 was admitted to the facility 3/12/2013 with multiple diagnoses including COPD (Chronic Obstructive Pulmonary Disease). The resident's August 2015 care plan documented the resident used oxygen all the time and staff should be sure oxygen saturation was over 90%.	F 314 F 328	F-328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility will ensure that oxygen is administered as ordered. Resident # 10 will have oxygen liter flow rate on continuous as ordered with exception of times of her choosing to not wear oxygen as her personal preference. Resident is aware of any potential adverse effects that may arise as result of not wearing oxygen continuous. EXHIBIT F-328 #1 COPY OF SIGNED RISK AND BENEFIT WAIVER AND COPY OF PHYSICIAN ORDER 8/27/2015. Any resident residing at the facility that receives oxygen from mechanical means has the potential to be affected. All residents who have orders to receive oxygen will be audited for oxygen orders to contain the following: Liters per minute to be administered, specified time to administer oxygen, when to monitor oxygen saturations, target saturation levels, instructions of what to do if	10/9/15

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F 328	<p>Continued From page 13</p> <p>On 12/17/13 an order for continuous oxygen was ordered at 2 L (liters) via nasal cannula. Instructions with the order documented oxygen saturation should be monitored every shift and to notify the MD if oxygen saturation was below 90%.</p> <p>a. On 8/26/15 at 11:30 a.m., the resident was in bed with a nasal cannula in her nose and the oxygen concentrator was turned to the off position.</p> <p>At 11:40 a.m., the DON stated the oxygen concentrator was not on. When it was turned on, it was set at 2.5 litres, rather than the 2 liters ordered.</p> <p>b. On 8/26/15 at 6:55 p.m., the resident was observed at the evening meal service with no oxygen being administered. Upon return to her room, her oxygen saturation read 87% on room air. The resident stated she felt short of breath at dinner.</p> <p>On 8/27/15 at 8:45 a.m., the resident was observed at the morning meal service with no oxygen being administered. LN #4 took the resident's oxygen saturation which read 79% on room air. She offered oxygen to the resident but the resident stated she did not want it. The LN stated the resident has never wanted oxygen at meals.</p> <p>On 8/27/15 at 10:00 a.m., the DNS stated 8/26/15 was the first time she was aware of the resident not wearing oxygen in the dining room. The DNS was unsure of when the resident had first started this refusal in the dining room and said she would investigate this.</p>	F 328	<p>saturation falls below target saturation level, what to do if saturations cannot be maintained above designated saturation percentage and notify MD for further instructions when needed. Furthermore all residents with oxygen orders will be audited for concentrator, oxygen buddy, mister machine and CPAP settings to be as ordered. Licensed nurses will be educated regarding oxygen orders, physician notification and documentation needs for oxygen use.</p> <p>EXHIBIT F-328 #2 AUDIT OF OXYGEN ORDERS</p> <p>EXHIBIT F-328 #3 IN-SERVICE OF LICENSED NURSES FOR OXYGEN ORDERS, PHYSICIAN NOTIFICATION AND DOCUMENTATION NEEDS FOR OXYGEN USE</p> <p>EXHIBIT F-328 #4 COPY OF OXYGEN ADMINISTRATION POLICY REVIEW</p> <p><i>Exhibit F328 #5 O2 to be posted at NS</i></p> <p>The facility will put in place random auditing for compliance with oxygen being administered as ordered and MD notifications documented when saturations are not maintained. Systemic changes will include that oxygen orders criteria will be listed at each nurse station for review when new orders are received for oxygen.</p>		

Cynthia M. Reedel Adm 9-24

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F 328	Continued From page 14 Following this interview, the MD was notified, resident education was provided, new orders were received, and the care plan was updated. On 8/28/15, the DNS stated the resident has never worn oxygen in the dining room due to her preference to be socially compatible with other residents, and was not notified of this until 8/26/15. It was not made clear how long the issue had been going on, nor why it had not been addressed prior to the surveyor's observations.	F 328	EXHIBIT F-328 #6 OXYGEN ORDERS CRITERIA POSTED AT NURSE STATION The facility will monitor performance to ensure the corrective actions are effective and compliant by auditing all residents who have orders for oxygen to receive oxygen as ordered: <ul style="list-style-type: none"> • Weekly x four weeks. • Then bi-weekly x 2 months then • Monthly x 9 months. Auditing and education will increase in frequency if needed until compliance is maintained. Trending of audits will be reported to QAPI team/medical director monthly.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	F356 Posted Nurse Staffing Information The facility will display the nurse staffing posting in a prominent place readily accessible to residents and visitors.	10/19/15

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F 356	<p>Continued From page 15 for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to display the nurse staffing posting in a prominent place readily accessible to residents and visitors. This affected 7 of 7 (#s 1-7) sampled residents and had the potential to affect all residents who resided in the facility and any visitors who came to the facility. Findings included:</p> <p>On 8/24/15 at 4:25 PM, the Administrator was asked where the nurse staffing information was posted. The Administrator took the surveyor to the Nurses Station between the North and South Halls. The information was posted around the corner on the West wall next to the medication room. The posting was not readily accessible to residents and visitors. The Administrator pointed to the sheet, which posted the census and nurse staffing, for the previous shift. This information did not document the census and nurse staffing information for 8/24/15 day shift. The Administrator asked the desk nurse to put up the day census sheet and stated she would orient the new nurse to make sure this was done on a daily basis.</p> <p>The administrator stated she would move the daily census posting and the nurse staffing to the hallway where it would be visible to everyone.</p>	F 356	<p>This has the potential to affect all residents who reside in the facility and any visitors who came to the facility</p> <p>The Nurse Staff posting is posted in a prominent place readily accessible to residents and visitors.</p> <p>Night shift will post the required staffing postings daily for the 24 hour period. Any changes in staffing will be corrected in the 24 hours if staffing changes</p> <p>LNS staff were inserviced on this posting and requirements of being posted in a prominent place. See inservice Posting Exhibit #1</p> <p>New daily posted was put in place see new daily posting Posting Exhibit #2</p> <p>Audits will be completed by the Administrator /or Designee</p> <p>Weekly x 4 weeks, Bi weekly X 2 months Monthly X 9 months</p> <p>Trending and audits will be presented at the monthly QAPI team and medical director..</p>	10/9/15

Cynthia M. Riedel

Adm

9-24-15

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F 369 F 369 SS=D	Continued From page 16 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not ensure specialized eating equipment was provided for residents who needed it. This was true for 1 of 7 residents (#5) sampled for adaptive equipment. The deficient practice had the potential to cause harm if residents experienced difficulty when eating or had weight loss due to not having the assistance of a compartment plate. Findings included: Resident #5 was admitted to the facility on 12/29/14 and on 1/24/15 with multiple diagnoses which included flaccid hemiplegia on the left side, dysphasia due to cerebral vascular accident and cognitive communication. The nutritional care plan, initiated 3/4/15, documented the resident used a compartment plate, so he could be independent, needed set-up help but could feed himself. On 8/25/15 at 8:45 AM, Resident #5 was observed at the breakfast meal with cream of wheat, toast and applesauce on a regular plate. The resident's preference card, which was close to the resident's plate, documented the resident was to have a compartment plate. CNA #11 was shown the resident's preference card and stated the resident did not have a compartment plate.	F 369 F 369	F369 Assisted Devices Eating Equipment/Utensils The Facility will ensure that specialized eating equipment is provided for residents who need it . Resident #5 will be sent out a compartment plate with all meals. All residents that need specialized eating equipment could be affected by this practice. A in-service was completed including a <ul style="list-style-type: none"> Review of adaptive equipment The reason why resident need the equipment and a review of the plan of correction and the audits exhibit F369 # A list of all residents on adaptive equipment is posted in the kitchen above tray line and updated weekly Monthly in-service on adaptive assistive devices by RD DM or OT/ST Diet Cards reviewed and audited by kitchen staff member <ul style="list-style-type: none"> Weekly X 4 weeks Bi-weekly X 2 months Monthly x 9 months 	10/9/15

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

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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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2016
NAME OF PROVIDER OR SUPPLIER DESERT VIEW CARE CENTER OF BUHL			STREET ADDRESS, CITY, STATE, ZIP CODE 820 SPRAGUE AVENUE BUHL, ID 83316	
(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)	(X6) COMPLETION DATE
F 369	Continued From page 17	F 369	Weekly audit of tray line for compartment plates and all adaptive equipment	
F 441 SS=E	<p>On 8/27/15 at 4:00 PM, the DM was made aware of the observation and stated the resident should have had a compartment plate.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p>	F 441	<p>Weekly audit of tray line for compartment plates and all adaptive equipment</p> <ul style="list-style-type: none"> Weekly X 4 weeks Bi-Weekly X 2 months Monthly X 9 months <p>All audits will be trended and reported to monthly QAPI team and Medical Director</p> <p>F441 Infection Control 483.65 Infection Control Prevent Spread and Linens</p> <p>The facility will follow the infection control policy and procedures.</p> <p>Sample residents #2,4,5. The corrective action for these residents is education to staff regarding hand washing, glove use, and tray use for med administration and audits.</p> <p>All residents admitted to DVCC have the potential to be affected.</p>	10/9/15

Cynthia M. Reedel Admin 9-24-15

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

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F 441	<p>Continued From page 18</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to follow the infection control policy and procedures. This was true for 3 of 11 sampled residents (#2, #4, & #5). This created the potential for infections to spread to other residents when a CNA did not change her gloves or perform hand hygiene immediately after perineal care (peri-care) of Resident #2, an LN did not wear gloves while checking Resident #4's blood sugar, and when an LN did not disinfect the medication tray after administering medications to Resident #4 and Resident #5. Findings include:</p> <p>1. Resident #2 was admitted to the facility 8/20/14 with multiple diagnoses including generalized muscle weakness.</p> <p>On 8/25/15 at 11:20 a.m., CNA #2 and LN #1 were observed providing perineal care for the resident. After wiping the resident's perineal area, CNA #2 replaced the resident's attends, put pants on the resident, used the hoyer sling to transfer the resident to the wheelchair, then changed her gloves. After combing the resident's hair, the CNA performed hand hygiene. Immediately following, the CNA stated she changed her gloves after getting the resident out of bed, but not right after peri-care and did not wash her hands after peri-care.</p> <p>2. Resident #4 was admitted to the facility</p>	F 441	<p>Corrective actions will include</p> <ul style="list-style-type: none"> skills checks (see exhibit INF #1) to be completed on all current LNs and CNAs employed. In-service regarding hand washing, barrier trays (either fry or plastic) and glove use. New staff educated through orientation-see orientation check off sheet (see exhibit INF #2). <p>Systemic changes that will be in place will be:</p> <ol style="list-style-type: none"> In servicing and re-educating staff about using hand sanitizer-using the small containers in the pyxis for in their pockets. Encouraging use of new disposable fry trays when applicable. New staff orientation check off/education sheet will have policy/procedures for glove use and hand hygiene added. <p>Random auditing will be completed on Gloves/hand washing-exhibit INF #3</p> <ul style="list-style-type: none"> 10 staff members for hand washing and use of gloves. 		

Cynthia M. Redel

Adm

9-24-15

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

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F 441	Continued From page 19 7/30/1997 with multiple diagnoses including Diabetes Mellitus. The resident's diabetic care plan, initiated 6/23/15, documented the resident may check her own blood sugar by piercing her own finger and placing the blood on the glucometer strip with nurse supervision. On 8/26/15 at 3:15 p.m., LN #3 Supervised the resident's blood sugar check. The resident pierced her finger, and the LN helped the resident squeeze her finger to form a drop of blood. The LN was not wearing gloves during this observation. Immediately after, the LN stated she did not wear gloves when checking the resident's blood sugar. On 8/27/15 the DNS stated the LN should have worn gloves during the blood sugar check. 3. During the previous example, the materials for Resident #4's blood sugar check and medications were carried to the resident via a medication tray. After this observation, LN #3 set the tray on the medication cart, put new medications for Resident #5 on it, then administered medications to Resident #5. The tray was then set on the resident's chair, the LN took out the garbage while holding the medication tray, and the tray was brought back to the medication cart. The tray was not sanitized between residents. The LN stated the medication tray should be sanitized between each resident. On 8/27/15 the DNS stated the medication tray should be sanitized between each use.	F 441	<ul style="list-style-type: none"> Audits will be performed weekly x4weeks. Biweekly x2 months. Monthly x 9 months Auditing will be increased if trending shows concerns. <p>Blood sugar checks (trays) and gloves/hand washing -exhibit INF#4</p> <ul style="list-style-type: none"> 4 nurses regarding appropriate blood sugar checks (including glove use and hand washing)and use of disposable trays and/or sanitizing of plastic trays. Audits will be performed weekly x4weeks. Biweekly x 2 months. Monthly x 9 months. Auditing will be increased if trending shows concerns. <p>Ensure compliance by trending audits and reporting to QAPI monthly to team and Medical Director.</p> <p>Audits to include:</p> <ol style="list-style-type: none"> Hand washing Gloves Medication Tray 		
F 465	483.70(h)	F 465			

Cynthia M. Riedel

adm 9-15-24

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

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F 466 SS=	Continued From page 20 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure flooring in the food preparation area of the kitchen was maintained in a cleanable condition. This affected 10 of 10 (#s 1-10) sampled residents, and had the potential to affect all residents who dined in the facility. This practice created the potential to expose residents to disease causing pathogens. Findings included: On 8/24/15 at 10:45 AM, the floor in the food preparation area of the facility's kitchen was observed to be an industrial non skid material. There were multiple dents, dings, indentations, and sills in the floor surface. The floor when new had been a marbled pink color, but now had a dingy ground-in dirt appearance. There appeared to be dark brown debris build-up around the edges of the floor surface, and in the corners near the food preparation area. The red tape on the floor, to alert staff to put on a hair net before proceeding any further, was not continuous and had chunks of missing tape. On 8/24/14 the DM stated the floor needed to be redone and the facility planned on getting a new floor. She stated the floor was really old and there were a lot of marks and sills in the flooring. She stated the facility had attempted to steam-clean	F 465	F465 Safe Clean Comfortable Homelike Environment addendum The Facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings. All residents of the facility have the potential to be effected by this practice The flooring in the kitchen will be thoroughly clean q shift at the end of shift and PRN New Flooring has been ordered by Gentry flooring and will be replace Oct 26, 27, and 28 . Deep cleaning of the floors in the kitchen will occur bi monthly with sideboards and flooring deep cleaned. Audits of the cleanliness will be completed on the flooring of the kitchen by ADM/or kitchen supervisor Weekly X 4 weeks Bi Weekly x 2 monthly Q month X 9 months Auditing and education will increase in frequency if needed until compliance is maintained . Any audits issues will be reviewed at the monthly QAPI/Medical Director	10/6/15

Cynthia M. Reed ^{adm} 10/1/15

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

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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 83318		
(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)	(X6) COMPLETION DATE	
F 465	Continued From page 21 the kitchen floor, but it had just smeared the dirt around. On 8/27/15 the Administrator stated the facility had budgeted for new flooring for the kitchen, but it had not yet been replaced.	F 465			

Cynthia M. Reed Adm 9-24-15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001750	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2015
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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) COMPLETE DATE
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Kendra Deines, RN, BSN	C 000	C664 Required Members of Infection Control Committee The facility will ensure that all required members of the Infection Control Committee will include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative present for quarterly infection control meeting.	10/9/15
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the there was a designated Infection Control Committee that included all required members. This had the potential to affect all residents in the facility who were vulnerable to nosocomial infections. Findings include: On 8/27/15 at 10:00 a.m., Infection control quarterly meeting attendance was reviewed with LN #. The MD and dietary representative were not listed on the 8/11/15 Infection Control Meeting signature sheet. The LN stated the MD was not at the meeting and could not remember if there was a dietary representative.	C 664	This has the potential to affect all residents in the facility who are vulnerable to nosocomial infections. The quarterly infection control meeting will include all the required members. New signature sheet has been drawn up where members will sign next to their names to ensure they are not only present but have signed the minutes. See new Infection Control Meeting signature sheet-exhibit C664 #1. Audits will be done quarterly to ensure attendance. Any concerns of nonattendance will be reported to QAPI.	

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Cynthia M. Riedel</i>	<i>Administrator</i>	9/25/15



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
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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

November 24, 2015

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

Provider #: 135089

Dear Ms. Riedel:

On **August 28, 2015**, an unannounced on-site complaint survey was conducted at Desert View Care Center Of Buhl. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006998

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted August 24, 2015 through August 28, 2015.

The following observations were completed:

Direct care staff and management staff interactions with residents during the survey week;
Direct care staff during the provision of care for ten residents;

The following documents were reviewed:

The entire medical record for the identified residents;
Nine other residents record were reviewed for quality of care concerns;
The facility's Grievance file from March 2015 through August 2015;
Resident Council minutes from June 2015 through August 2015;
The facility's Incident and Accident reports from March 2015 through August 2015;
The facility's Allegation of Abuse reports from March 2015 through August 2015.
The facility's Abuse Policy.

The following interviews were completed:

The Director of Nursing Services and the Administrator were interviewed regarding various quality of care concerns;

Three individual residents, including an identified resident, were interviewed regarding quality of care concerns;

An identified resident's family member, with two other family members, were interviewed regarding quality of care concerns;

A group of seven residents were interviewed regarding quality of care concerns; and,

Two Licensed Nurses and two Certified Nursing Aides were interviewed regarding quality of care concerns.

Allegation #1: The resident was not provided privacy and was seen from the hall unclothed in his room.

Findings #1: Privacy for all residents was investigated as part of the recertification survey. Based on observations of residents, observations of cares provided by staff, resident group interview, and family and individual resident interviews, it was determined the allegation could not be substantiated based on the lack of evidence.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Two Certified Nursing Aides were told a resident was soiled and needed care. They stated they would pass this care onto the next shift and the resident wasn't changed for approximately 50 minutes.

Findings #2: Based on record review and staff interviews, it was determined this allegation was substantiated and the facility was cited at F225.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: On April 23, 2015, two Certified Nursing Aides worked with residents following an allegation of abuse and continued not to change the same resident an entire shift.

Findings #3: Based on review of staff time sheets and interviews with staff, this concern was unsubstantiated based on the lack of evidence.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The facility did not investigate an allegation of neglect and the accused individuals were not suspended from work.

Findings #4: Based on staff interviews and record review, it was determined the allegation was substantiated and the facility was cited at F225.

Cynthia Riedel, Administrator
November 24, 2015
Page 3 of 3

Conclusion #4: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #5: A Certified Nursing Aide spoke in a rude, loud, and abrasive manner to a resident and told him not to use his call light so frequently. This was reported but no action was taken by the facility.

Findings #5: Record review of allegations of verbal abuse were investigated. The identified resident and other residents were interviewed, along with multiple Certified Nursing Aides and nurses. It was determined this concern could not be substantiated based on a lack of evidence.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,


DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt.



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
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January 12, 2016

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

Provider #: 135089

Dear Ms. Riedel:

On **August 28, 2015**, an unannounced on-site complaint survey was conducted at Desert View Care Center Of Buhl. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006980

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on August 24, 2015 to August 28, 2015.

Observations of direct care staff interactions with residents were made over the five day period, including call light response times, provision of care, distribution of fluids, and assistance at meal times. No concerns were identified in these areas as a result of those observations.

Interviews were conducted individually with multiple residents, residents in a group setting, and the identified resident's family member. Multiple CNAs and Licensed Nurses (LNs) were interviewed regarding quality of care concerns. The Administrator and the Director of Nursing were interviewed regarding the reported incident and the facility's investigation. No concerns with care delivery or call light response times were identified through resident, staff, or family interviews.

The medical records for 11 residents including the identified resident were reviewed. The facility's grievance files, incident and accident reports, reports of allegations of abuse, Resident Council meeting minutes, the two identified CNA personnel files, and the staffing hour records were reviewed.

Allegation #1: The Reporting Party stated two identified Certified Nurse Aides (CNAs) went into an identified resident's room and told the resident he/she could not use his/her call light every ten minutes and placed it out of the resident's reach. Additionally, the CNAs did not change the resident for approximately three hours after he/she soiled himself/herself. These incidents were reported to an identified charge nurse, a letter regarding these incidents was written by the reporting party and given to the Administrator and Director of Nursing but there was no action taken.

Findings #1: Based on observation, staff and family interviews, and record review, this allegation was substantiated based on the facility's failure to document the investigation of the reported allegation. The facility was cited at F-225.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: The complainant stated an identified resident left the facility in a wheelchair and was found by staff wheeling himself/herself down the sidewalk.

Findings #2: Based on record review and staff interviews, there were two incidents where the identified resident was found outside of the facility. A completed Incident and Accident report along with a thorough investigation was completed for both incidents. Therefore, this allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Allegation did not occur.

Allegation #3: The complainant stated the facility was short staffed, especially at meal times, call lights were not answered timely, and water was not passed until late in each shift.

Findings #3: Based on observations, staff and resident interviews, and review of staffing hours, this allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Allegation did not occur.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

Cynthia Riedel, Administrator

January 12, 2016

Page 3 of 3

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson".

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt