



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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 22, 2016

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 14, 2016**, 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. 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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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 the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 4, 2016**. Failure to submit an acceptable PoC by **April 4, 2016**, may result in the imposition of civil monetary penalties by **April 24, 2016**.

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 18, 2016**, (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 18, 2016**. A change in the seriousness of the deficiencies on **April 18, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 18, 2016**, includes the following:

Denial of payment for new admissions effective **June 14, 2016**.
42 CFR §488.417(a)

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 14, 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, 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 14, 2016**, 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:

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<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 **April 4, 2016**. If your request for informal dispute resolution is received after **April 4, 2016**, 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,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 03/22/2016
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 03/14/2016
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V(111) construction with a partial unfinished basement. It has corridor smoke detection and sprinkler coverage, built in 1958. It has off site monitoring, with 6 exits to grade, plus the service exit. The facility is currently licensed for 57 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 14, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Fire Life Safety & Construction</p>	K 000		
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression system pendants were maintained free of obstructions such as corrosion or paint. Failure to maintain suppression system pendants free of obstructions could result in a lack of system performance during a fire event. This deficient practice affected 23 residents, staff and visitors on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 39 on the day of the survey.</p>	K 062		

RECEIVED
APR - 4 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia M. Reed</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/31/16</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 062	<p>Continued From page 1 Findings include:</p> <p>During the facility tour conducted on March 14, 2016 from approximately 11:00 AM to 3:45 PM, observation of the fire suppression system pendants revealed the following:</p> <ol style="list-style-type: none"> 1) The public restroom abutting the RSC/MDS office had a painted sprinkler head. 2) The main Kitchen had one (1) corroded sprinkler head over the dishwashing area and three (3) painted heads over the main cookline. 3) The Hopper room and the Shower room by resident room 15N each had one (1) corroded sprinkler head. 4) The main Laundry had one (1) corroded sprinkler head. 5) The closet in room 10N contained one (1) corroded sprinkler head. 6) Room 5S had two (2) corroded heads in the sleeping area and one (1) painted head in the closet. <p>When asked, the Maintenance Supervisor stated he was not aware of the condition of these sprinkler heads prior to the survey.</p> <p>Actual NFPA standard: NFPA 25</p> <p>2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1*</p> <p>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged,</p>	K 062		

Cynthia M. Reed

Administrative

3/13/16

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K 062	Continued From page 2 loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	K 062 The facility will ensure that the automatic sprinkler system is continuously maintained in reliable operating condition and are inspected and tested periodically.	4/18/16
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that wall mounted electric heaters were free of obstructions. Improper clearances and obstructions of electric wall heaters are historically linked to facility fires. This deficient practice affected staff and visitors of the dietary storage in the partial basement on the date of the survey. The facility is licensed for 57 SNF/NF beds and had a census of 39 on the day of the survey. Findings include: During the facility tour conducted on March 14, 2016 from approximately 11:00 AM to 12:00 PM, observation of the dietary storage area located in the partial basement (aka "Old Dietary Office") revealed a wall mounted cadet heater blocked by a freezer. When asked about the obstructed heater, the Maintenance Supervisor stated he was not aware of the heater in this location. Actual NFPA standard:	K 067 Sprinkler heads in the public restroom, RSC/MDS office, four in the kitchen, hopper room, north shower room, laundry room, 10 North, and three in 5 South will be replaced by Delta Fire Systems on 04-18-2016. The facility will be inspected by Delta Fire Systems and any sprinkler head that needs to be replaced will be done so by Delta. Maintenance supervisor will inspect sprinkler heads monthly and have Delta Fire Systems inspect yearly to ensure full compliance. Maintenance supervisor will report monthly to the CQI committee of any issues.		

Cynthia M. Reed Adm

3/31/16

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K 067	Continued From page 3 19.5.2 Heating, Ventilating, and Air Conditioning. 19.5.2.1 Heating, ventilating, and air conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications. Exception: As modified in 19.5.2.2.	K 067	<p>K 067</p> <p>The facility will ensure that the heating, ventilating, and air conditioning comply with the provisions of section 9.2 and the manufacturer's specifications See exhibit "A".</p> <p>The heater in the dietary storage has been removed as of 03-23-2016 see exhibit "B".</p> <p>All rooms in the building have been inspected to assure that all heaters comply with the provisions as of 3-23-2016.</p> <p>Maintenance supervisor will have heaters checked each shift each day see exhibit "C,D,E" until the temperature outside warms up and the power to the heaters gets turned off then inspections will be conducted monthly.</p> <p>Maintenance supervisor will report monthly to the CQI committee of any issues.</p>	4/18/16

Cynthia M. Reed Adm

HT 3/31/16