



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
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Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 1673

May 6, 2014

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

Provider #: 135089

Dear Ms. Riedel:

On **April 25, 2014**, a Recertification and State Licensure 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 one that comprises a pattern 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. **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 3). **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. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form

CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 19, 2014**. Failure to submit an acceptable PoC by **May 19, 2014**, may result in the imposition of civil monetary penalties by **June 9, 2014**.

The components of a Plan of Correction, as required by CMS include:

- 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 in place or what systemic change will you make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring.
 - * It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task.
 - * The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3.
 - * A plan for "random" audits will not be accepted.
 - * Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- 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.

Cynthia Riedel, Administrator

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- 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 **May 30, 2014 (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 **May 30, 2014**. A change in the seriousness of the deficiencies on **May 30, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2014** includes the following:

Denial of payment for new admissions effective **July 25, 2014**. [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 **October 25, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626; 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 **April 25, 2014** and continue until substantial

Cynthia Riedel, Administrator
May 6, 2014
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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 noncompliance 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:

- 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 **May 19, 2014**. If your request for informal dispute resolution is received after **May 19, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 05/06/2014
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 04/25/2014
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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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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: Sherri Case, BSW, LSW, QIPD, Team Coordinator Rebecca Thomas, RN</p> <p>The survey team entered the facility on April 21, 2014 and exited on April 25, 2014.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NN = Nurses Notes PA = Physician Assistant PRN = As Needed TAR = Treatment Administration Record</p>	F 000	<p>F 280</p> <p>The Facility will revise and update care plans as resident changes occur</p> <p>Resident #1, #2 and #6 care plans /behaviors plans were revised and updated to the changes</p> <p>Resident #1 and #2 CP/behavior plans were updated to reflect the detailed descriptions of the behaviors that the residents are exhibiting currently.</p> <p>Resident #6 Care plan was updated to reflect the resident needs concerning nutrition Care Plan. Staff was inserviced to the Plan of care for set up.</p> <p>(See attached Exhibit 1, 2, 3 and 4)</p>	
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed</p>	F 280		5/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cynthia M. Redif</i>	TITLE <i>Administrator</i>	(X6) DATE 5/19/14
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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 280 Continued From page 1
within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, it was determined the facility failed to revise and update care plans as resident changes occurred. This was true for 3 of 9 (#s 1, 2 and 6) residents sampled for care plans. This practice created the potential for the resident to experience unmet care needs. Findings included:

1. Resident #1 was admitted to the facility on 7/30/97 and readmitted on 1/19/13 with multiple diagnoses including anoxic brain damage, anorexia, hallucinations and unspecified episodic mood disorders.

The resident's 4/1/14 recapitulation Physician's Orders (POs), included an order for Depakote 500 mg twice daily for mood stabilizer and Zoloft 100 mg every day for adjustment disorder with depressed mood.

*The resident's 3/25/14 Behavior Management

F 280

All residents have the potential to be effected by this practice.

All residents CP/Behavior tracking will be reviewed at weekly IDT meeting to ensure that behaviors on CP are being tracked. If the behavior has not occurred for 3 months The IDT team will refer the behavior to the PDR team. PDR team will determine if the tracking needs to continue on the behavior or if that tracking of specific behaviors can be removed. If behavior is determined to be critical and still needs tracking it will stay in place even without numbers.

Cynthia M. Reed

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F 280 Continued From page 2
Care Plan (BMCP) for assaults included behaviors of hitting, kicking or slapping staff or peers, and verbal assaults of cursing at others.

Resident #1's Behavior Data Sheets (BDS) for the months of 3/14 and 4/14 documented there had been no incidents of physical or verbal assaults.

*The CP included a focus area of inappropriate sexual behaviors of inappropriate touching/comments and "innuendo." The CP did not describe what inappropriate touching/comments or innuendoes were. Without a description of the targeted behaviors staff would not know if a behavior met the criteria for data collection.

Resident #1's BDS for the months of 3/14 and 4/14 documented there had been no incidents of inappropriate sexual behaviors.

On 4/24/14 at 11:30 a.m., the RSD stated the care plan needed to be revised as the resident did not have some of the identified behaviors. The RSD was asked what the behaviors of touching inappropriately and an innuendo looked like. The RSD stated the specific behaviors were not described in the care plan.

2. Resident #2 was admitted to the facility on 3/8/12 and readmitted on 3/3/14 with diagnoses of end stage renal disease, diabetes and chronic airway obstruction.

The resident's CP included a goal of "to not harm myself." The interventions section included the resident would let the air out of her portable oxygen tank and the resident would leave the

F 280

Audits On resident #6 meal plan set up will occur as follows

Audits will occur:

Weekly X 4 weeks

Then 2 weeks X 4

Monthly X 3

start date of audit 5/19/14

Cynthia M. Reedif Adm

5/19/14

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F 280	<p>Continued From page 3 "property to sneak smokes."</p> <p>The BDS for 3/14 and 4/14 did not include an area to document the above concerns. Without data documenting the targeted behaviors it was not clear if the targeted behaviors were still a concern or the CP needed to be revised to discontinue the CP for the behaviors.</p> <p>On 4/23/13 at 3:15 p.m., the DON was informed of the above concerns. On 4/24/14 the DON provided an addendum to the Care Plan, however the facility did not provide any information regarding the resident sneaking smokes or letting the air out of the portable oxygen tank.</p> <p>3. Resident #6 was admitted to the facility on 3/27/12 and readmitted on 6/18/13 with diagnoses which included organic brain syndrome, depressive syndrome, dementia with behavioral disturbance and unspecified psychosis.</p> <p>The resident's 2/11/14 quarterly MDS assessment documented no hallucinations or delusions, extensive assistance of 2 staff to transfer and an upper extremity impairment on one side.</p> <p>The resident's nutrition care plan (CP) documented he was to use a compartment plate. The ADLs/Dental CP included in the intervention section "I like my food/drink set up a certain way when I eat. Please ask the staff that have been here long enough to know...."</p> <p>During a meal observation on 4/23/14 at 1:00 p.m. the resident's meal tray was placed in front of him. The resident's food was observed to be</p>	F 280		

Cynthia M. Reed 5/19/14
Adm

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F 280	<p>Continued From page 4</p> <p>on a divided plate, the aide placed the tray in front of the resident and left. A different CNA (#1) was present and the surveyor asked how the resident liked his food to be set up. CNA #1 stated she needed to fix the resident's tray, walked over to the resident and moved the drinks and silverware to the left on the tray. CNA #1 returned to the surveyor and said she was formerly a restorative aide and was aware of how to set up the meal tray. She also stated there was a picture of how to set up the tray in the meal monitor book but the picture did not have the resident's name on it.</p> <p>On 4/23/14 at 3:45 p.m., the surveyor asked the DON how the resident preferred his meal tray to be arranged. The DON stated the CP needed to be revised to include specific interventions how the resident's meal tray was to be set up.</p> <p>During the evening meal on 4/23/14 at approximately 6:00 p.m. the resident was observed seated at the dining table. The resident's drinks and eating utensils were observed to be on the tray on the resident's right side. CNA #1 was assisting another resident to eat. CNA #1 noticed Resident #6's meal was not set up correctly. CNA #1 expressed frustration the tray had not been set up correctly and stopped assisting the other resident to set up the tray correctly for Resident #6.</p> <p>On 4/24/14 the facility provided a nutrition CP which was revised to include the resident was not able to use his right side, and the drinks and eating utensils needed to be on the left side of his meal tray.</p> <p>The Administrator, DON and the RSD were informed of the concerns on 4/25/14 at 12:50</p>	F 280		

Cynthia M. Reed Adm 5/19/14

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F 280 F 309 SS=D	Continued From page 5 p.m. The facility provided no further information. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure residents received the necessary care and services to attain or maintain their highest practicable well-being: * Ensuring continuity of care between the dialysis center and the facility for Resident #2. * Ensuring care plan interventions were implemented for Resident #6. * Ensuring the development of an individualized care plan to meet the needs of a resident (#5) with dementia who received psychopharmacological medication. These practices affected 3 of 7 sample residents (#s 2, 5 & 6) and placed the residents at risk for unmet care needs. Findings included: 1. Resident #5 was admitted to the facility on 3/29/13 with diagnoses which included dementia with behavioral disturbance, depressive disorder, and pain. The resident's 2/11/14 quarterly MDS	F 280 F 309	F-309 The facility will ensure residents receive the necessary care and services to attain or maintain their highest practicable well being. Resident # 2 will have a communication form between dialysis and facility. Care plan will include interventions of give resident all medications, treatments, labs as ordered, follow renal diet/fluid restrictions, monitor left arm for signs and symptoms of infection and will refer to see dialysis care plan. The care plan will also include how to manage emergencies. (see exhibit 5 a and 5 b) Resident # 5 will have behavior data sheets implemented to include verbal and physical assaults, refusing of cares, clearer definitions of delusions/hallucinations for	

5/19/14

Cynthia M. Reas 5/19/14

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F 309	<p>Continued From page 6</p> <p>assessment documented delusions and no behaviors. The 3/28/14 quarterly MDS assessment documented hallucinations, delusions and behaviors.</p> <p>The resident's Medication Administration sheet for 4/14 documented she received Haldol (antipsychotic) 1 mg every day for psychosis until 4/10/14 when the Haldol was increased to 1.5 mg. The resident received Depakote (anticonvulsant) 250 mg 3 times a day for mood stabilization.</p> <p>The resident's 1/4/14 Care Plan (CP) for behaviors included verbal and physical assaults, refusing cares, delusions/hallucinations (hearing things not there and believing to be true), and socially inappropriate behaviors of smearing feces and disrobing.</p> <p>Resident #5's Behavior Data Sheets (BDS) for 3/14 and 4/14 did not have an area to document behaviors of smearing feces or disrobing. The BDS documented 1 physical assault for March and 66 verbal assaults (yell profanities and threaten). There were no verbal or physical assaults documented for 4/14.</p> <p>On 4/23/14 at 3:30 p.m. the DON stated the resident had not had behaviors of smearing feces or disrobing for some time.</p> <p>On 4/24/14 at 11:30 a.m., the RSD stated the delusions were the resident believed she was employed by the facility. Resident #5 would get upset and yell at the other residents as she thought they were doing "things" wrong. The RSD was informed the CP did not include targeted specific behaviors identifying what the delusions</p>	F 309	<p>her. Socially inappropriate behavior of smearing feces and disrobing have been discontinued and removed from behavior tracking and care plans.</p> <p>Resident # 6 will have meal trays set up per residents preference.</p> <p>Any resident that receives dialysis, requires specific way to set up meal trays and any resident that has diagnosis of dementia with behavior and receives psychopharmacological medications will have the potential to be affected.</p> <p>Resident #2: Dialysis residents will have a form for communication to ensure continuity of care between this facility and dialysis center. This form will be initiated by this facility and delivered with resident attending dialysis for the dialysis staff to complete and return with resident when dialysis is completed. Facility nurse will ensure that this form is returned or will follow up</p>	
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Cynthia M. Reed Adm 5/19/14

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F 309	<p>Continued From page 7 were for the resident.</p> <p>During observations on 4/22/14 at 1:00 p.m. and on 4/23/14 at 10:30 a.m., the resident was observed alone in her room reading a book. The resident stated she enjoyed reading and liked to read all the time.</p> <p>The resident's 1/24/14 CP for depression documented depression was displayed by negative comments, sad affects, isolation and increasing hours of sleep.</p> <p>The CP did not specify what isolation, negative comments or "increasing hours of sleep" looked like. The section to document increasing sleep did not include how this was demonstrated i.e. additional naps in afternoon, sleeping in later in the morning or going to bed earlier. Additionally the BDS sheet only had the signs and symptoms of depression as tearfulness and negative comments and did not include an area to document isolation or sad affect.</p> <p>The intervention section of the CP stated to document behaviors and hours of sleep and to keep the resident's call light within reach. It did not include interventions such as redirection by discussing current books the resident was reading, activities which were available, etc.</p> <p>The Administrator, DON and the RSD were informed of the concerns on 4/25/14 at 12:50 p.m. The facility provided no further information.</p> <p>2. Resident #2 was admitted to the facility on 3/8/12 and readmitted on 3/3/14 with diagnoses of end stage renal disease, diabetes and chronic airway obstruction.</p>	F 309	<p>with phone call to dialysis requesting form then be faxed to facility for communication needs. Residents with dialysis care plan will include interventions of give resident all medications, treatments, labs as ordered, follow renal diet/fluid restrictions, monitor left arm for signs and symptoms of infection and will refer to see dialysis care plan. The care plan will also include how to manage emergencies. Medical records will be reviewed monthly for maximization and effectiveness of medications and to avoid adverse effects. (see exhibit 6 inservice to staff , exhibit 7 letter from dialysis exhibit 8 8 signatures from dialysis center on meds.</p> <p>Resident #5: Residents with diagnosis of dementia and who are receiving psychopharmacological medications will have clearly defined and reviewed during</p>		

Cynthia M. Ruedy Adm 5/19/14

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F 309	Continued From page 8 Resident #2's medical record documented she was to attend dialysis 3 times a week. The resident's 3/19/12 CP for skin/pressure included a focus area of "swelling around shunt." The intervention section included the physician and the nurse at dialysis, "will monitor shunt and arm for increased swelling and need for further TX (treatment) LN will monitor area Qshift (every shift) as well and report to MD promptly." The resident's 3/19/12 CP with a focus area of Dialysis related to diagnoses of end stage renal failure included interventions of: "Give me all my meds, TX, labs" "Follow renal diet/fluid restrictions..." "Monitor left arm for S/S (signs and symptoms) infection..." "See (dialysis facility) care plan..." Note: The CP included no information on regular communication with the dialysis facility, how to manage emergencies and complications due to bleeding/hemorrhaging or infection/bacteremia/septic shock. The resident's "Patient Plan of Care" (CP) from the dialysis center included goals for the dialysis prescription, blood pressure and fluids, anemia, albumin management, body weight, mineral metabolism and dialysis access. The CP included no information regarding how to manage emergencies. The resident's medical record did not document the physician had reviewed the resident's medication orders to indicate if medications were to be administered before or after dialysis to	F 309	Psychotropic Drug Review monthly meetings for those residents who are in review cycle. Residents will also be reviewed weekly during Interdisciplinary Team meetings. Care plans will be updated as needed and with MDS cycle. Any behavior including verbal and physical assaults, refusing cares, delusions/hallucinations (hearing things not there and believing to be true) and socially inappropriate behaviors of smearing feces and disrobing; sign or symptom of depression such as negative comments, sad affects, isolation and increased hours of sleep will be included in both the care plan and in the behavior tracking with specifics of what this will appear like. . Care plan interventions will be implemented in clear, descriptive manner for residents that require specific placement of items on their meal trays.	

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F 309	<p>Continued From page 9</p> <p>maximize their effectiveness and avoid adverse effects.</p> <p>The resident's medical record did not include documentation or evidence of communication with the dialysis center the days the resident went for dialysis.</p> <p>On 4/23/14 at 3:15 p.m., the DON stated the facility did not have a communication system with the dialysis facility for the days the resident went to dialysis. The DON was asked if the facility communicated with the dialysis center prior to the dialysis treatment the resident's blood pressure, meal consumption, or mental status etc. The DON said the facility sent no information to the dialysis center the days the resident received treatment. The DON also stated the dialysis center did not have written documentation from the dialysis center about any concerns or medical information from the dialysis center after the resident's treatment. The DON was informed the communication between the dialysis center and facility was needed to ensure continuity of care.</p> <p>The Administrator, DON and the RSD were informed of the concerns on 4/25/14 at 12:50 p.m. The facility provided no further information.</p> <p>3. Resident #6 was admitted to the facility on 3/27/12 and readmitted on 6/18/13 with diagnoses which included organic brain syndrome, depressive syndrome, dementia with behavioral disturbance and unspecified psychosis.</p> <p>The resident's 2/11/14 quarterly MDS assessment documented the resident required extensive assistance for eating.</p>	F 309	<p>Resident #6: Care plan will be updated to include specifics of certain way resident prefers this be set up. Dietary department will include specifics to be entered onto the dietary tray cards for dietary staff to assist with placement of items in residents certain way.</p> <p>Corrective action monitoring for dialysis communication, care plans will be completed by DON, charge nurse and medical records nurse. Monitoring will consist of ensuring that communication forms are exchanged daily and care Plans up to date</p> <p>All residents CP/Behavior tracking will be reviewed at weekly IDT meeting to ensure that behaviors on CP are being tracked and individualized. If the behavior has not occurred for 3 months The IDT team will refer the behavior to the PDR team. PDR team will determine if the tracking</p>	

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F 309	<p>Continued From page 10</p> <p>The resident's ADLs/Dental CP included in the intervention section "I like my food/drink set up a certain way when I eat. Please ask the staff that have been here long enough to know...."</p> <p>During a meal observation on 4/23/14 at 1:00 p.m. the resident's meal tray was placed in front of him. The resident's food was observed to be on a divided plate, the aide placed the tray in front of the resident and left. A different CNA (#1) was present and the surveyor asked how the resident liked his food to be set up. CNA #1 stated she needed to fix the resident's tray, walked over to the resident and moved the drinks and silverware to the left on the tray. CNA #1 returned to the surveyor and said she was formerly a restorative aide and was aware of how to set up the meal tray. She also stated there was a picture of how to set up the tray in the meal monitor book but the picture did not have the resident's name on it.</p> <p>On 4/23/14 at 3:45 p.m., the surveyor asked the DON how the resident preferred his meal tray to be arranged. The DON stated the CP needed to be revised to include specific interventions how the resident's meal tray was to be set up.</p> <p>During the evening meal on 4/23/14 at approximately 6:00 p.m., the resident was observed seated at the dining table. The resident's drinks and eating utensils were observed to be on the tray on the resident's right side. CNA #1 was assisting another resident to eat. CNA #1 noticed Resident #6's meal was not set up correctly. CNA #1 expressed frustration the tray had not been set up correctly and stopped assisting the other resident to set up the tray correctly for Resident #6.</p>	F 309	<p>needs to continue on the behavior or if that tracking of specific behaviors can be removed. If behavior is determined to be critical and still needs tracking it will stay in place even without numbers.</p> <p>Audits On resident #6 meal plan set up will occur as follows and audited by charge nurse who is in charge of the meal</p> <p>This will be monitored: Weekly x 4 weeks, Then every 2 weeks x 4 weeks Then monthly x 3.</p> <p>Corrective actions will be completed by May 19, 2014</p> <p><i>Start date of audits 5/19/14</i></p>	

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F 309	Continued From page 11 On 4/24/14 the facility provided a nutrition CP which was revised to include the resident was not able to use his right side and the drinks and eating utensils needed to be on the left side of his meal tray.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores 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. 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 of pressure ulcers. This was true for 3 of 11 (#'s 3, 7 & 8) sampled residents. This failure created the potential that residents would develop additional pressure ulcers, causing pain and potential for infection. Findings included: 1. Resident #3 was admitted to the facility on 5/10/13 with multiple diagnoses which included	F 314	F-314 Based on a comprehensive assessment, the facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This facility will provide the necessary nursing care and services to prevent the development of pressure ulcers.	5/19/14

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F 314	<p>Continued From page 12</p> <p>atrial fibrillation, depression, protein-calorie malnutrition and osteoporosis.</p> <p>The resident's most recent quarterly MDS, dated 1/21/14, documented: *Extensive assistance with 2+ persons for bed mobility, transfers, toilet use, ambulation in the room and in the corridor; *Extensive assistance with 1 person for dressing and bathing; *Total assistance with 1 person for locomotion on and off unit; and, *The resident was at risk but did not have pressure ulcers.</p> <p>The resident's significant change MDS, dated 3/21/14, was the same as above except it documented the resident had an unhealed pressure ulcer.</p> <p>The Clinical Assessment Report for Skin Risk Predictors Assessment, dated 5/10/13, documented a score of 12, indicating the resident was at high risk for skin breakdown.</p> <p>The care plan for pressure/skin, with an initial date of 5/20/13, documented interventions of: *Turn and reposition frequently and encourage to get out of bed; *RNA is working with the resident; *Notify LN/MD promptly of any new skin issues during cares, weekly/PRN skin check by LN; *Wear geri-sleeves to protect skin on arms; *Halo Bar for the resident to help turn and get out of bed; and; *2 person extensive assist for transfers.</p> <p>A Fall Incident and Accident Report, dated 3/1/14,</p>	F 314	<p>Resident #3 is currently deceased.</p> <p>Resident #7 and #8 will have wound documentation sheets that will include areas to describe exudates, characteristics of the wound and surrounding tissues, or if there is pain with dressing changes, care plans will include interventions to keep pressure off of documented current pressure sites. Risk and benefit will be documented for all residents who are experiencing pressure ulcers. (see exhibit 9)</p> <p>Resident #7 has use of heel protectors implemented and is included on care plan. (see exhibit 10)</p>	

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F 314	<p>Continued From page 13</p> <p>documented the resident attempted to self transfer, was found on the floor and reported she tried to get up from the recliner. No visible injury was noted.</p> <p>A Physician Telephone Order, dated 3/1/14 at 2130 (9:30 PM) documented, "unwitnessed fall - no injury, neuro checks WNL [within normal limits] - ROM [range of motion] WNL for resident."</p> <p>The pressure/skin care plan documented the following updates: * 3/4/14 - Turn every 2 hours until resolved, monitor and measure every week for open area to coccyx/sacrum. * 3/27/14 - Stage II pressure ulcer on coccyx, keep resident off coccyx as much as possible. * 4/20/14 - Resident did have an air mattress but was removed at the resident's request.</p> <p>NOTE: During record review, no documentation in the NN was found regarding an open area to the coccyx from 3/4 - 3/12/14.</p> <p>The March 2014 TAR, documented an open area to the coccyx/sacrum with the following measurements and orders:</p> <table border="0"> <thead> <tr> <th>Date</th> <th>Measurement</th> <th>Order</th> </tr> </thead> <tbody> <tr> <td>3/4/14</td> <td>2.5 X 2 cm</td> <td>Open area to coccyx/sacrum measure weekly, monitor daily.</td> </tr> <tr> <td>3/11/14</td> <td>2.5 X 3 cm</td> <td>No order given.</td> </tr> <tr> <td>3/12/14</td> <td></td> <td>Change Mepilex Q [every] 3 days & PRN. Notify M.D. if any complications.</td> </tr> <tr> <td>3/18/14</td> <td>3 x 2 cm</td> <td>Cleanse wound on R) upper buttock with saline, pat dry - cover wound with hydrocolloid dressing (Duoderm), every</td> </tr> </tbody> </table>	Date	Measurement	Order	3/4/14	2.5 X 2 cm	Open area to coccyx/sacrum measure weekly, monitor daily.	3/11/14	2.5 X 3 cm	No order given.	3/12/14		Change Mepilex Q [every] 3 days & PRN. Notify M.D. if any complications.	3/18/14	3 x 2 cm	Cleanse wound on R) upper buttock with saline, pat dry - cover wound with hydrocolloid dressing (Duoderm), every	F 314	<p>Resident #8 will have TAR updated to include that his feet are to be floated when he is in bed and will indicate that at times he will remove the pillows that are floating his heels. (see exhibit 11)</p> <ol style="list-style-type: none"> 1. All other residents with Skin at risk assessment score of <u> 18 </u> or lower will be at risk for pressure ulcers.. TAR will include area to document for floating of heels or use of heel protectors being done. 2. Systemic change will include implementation of wound and pressure sore documentation forms for wounds. Plan for each level of skin at risk upon admission with interventions to be implemented for each level. (see exhibit 13)
Date	Measurement	Order																
3/4/14	2.5 X 2 cm	Open area to coccyx/sacrum measure weekly, monitor daily.																
3/11/14	2.5 X 3 cm	No order given.																
3/12/14		Change Mepilex Q [every] 3 days & PRN. Notify M.D. if any complications.																
3/18/14	3 x 2 cm	Cleanse wound on R) upper buttock with saline, pat dry - cover wound with hydrocolloid dressing (Duoderm), every																

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F 314	<p>Continued From page 14</p> <p>3 days and PRN. 3/24/14 1 x .5 cm top No order given. .3 x .3 cm bottom</p> <p>3/26/14 Stage II pressure ulcer in coccygeal area, cleanse NS, pat dry, apply skin prep, apply Mepilex, change daily.</p> <p>NOTE: The TAR did not document exudate, characteristics of the wound and surrounding tissues, or if there was pain with dressing changes.</p> <p>On 3/12/14, a Condition Change Form filled out by LN #2, documented, "Residents open area to coccyx measures 3 cm x 2.5 cm, red with white center, small hole forming, non-blanchable, covered with Mepilex, on the right side of coccyx, turn resident Q [every] 2 hours while in bed and recliner to keep pressure off of right side of coccyx, change Mepilex Q 3 days PRN, monitor daily, measure weekly."</p> <p>NOTE: The care plan did not include an intervention to keep pressure off of right side of coccyx.</p> <p>On 3/18/14, a Condition Change Form, filled out by the DNS, documented, "PA requested to look @ [at] res [resident] coccyx area wound - Area not resolving - New order received for change padding in WC, WOCN to evaluate."</p> <p>On 3/18/14, the PA wrote a Progress Note which documented, "Stage I Decub [pressure ulcer] @ [at] right coccygeal area, with possible Stage II. Skin breakdown @ the center. Change padding on WC. Wound Care Specialist eval. Recheck if lesion persists."</p>	F 314	<p>3. This will be monitored by DON, MDS nurses and medical records nurse. Frequency of monitoring will include observing heels are floated, heel protectors are on weekly x 4 weeks, then Q 2 weeks x 4 then monthly x 3.</p> <p>Start date of these audits will begin May 19, 2014.</p> <p>4. Corrective actions will be completed by May 19, 2014</p>	

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F 314	<p>Continued From page 15</p> <p>The WOCN wrote a Progress Note, dated 3/18/14, which documented an open wound to the right side of coccyx which measured 1 x 1 cm with no obvious depth but had a bulging effect. She questioned whether this was pressure or a lesion from a fall on 3/1/14 with some shearing.</p> <p>NOTE: The open area on the coccyx was not documented until 3 days after the fall. Assessments at the time of the fall documented "no injury."</p> <p>A NN dated 3/26/14 at 9:23 PM, documented, "Resident has a Stage II pressure ulcer on the upper right side of her coccyx, scaly skin surrounding open areas, red and pink with white center, small hole noted x 2 places, superior (upper) open area measures 1.5 x .5 cm and inferior (lower) open area measures .3 x .3 cm, no drainage observed, nonblanchable in the center."</p> <p>The March 2014 Behavior Data Sheet, documented for the 31 days in March, the resident was resistive to cares for turning 0 of 31 day shifts, 1 of 31 evening shifts and 12 of 31 night shifts.</p> <p>A Progress Note by the WOCN, dated 4/1/14, documented, "wound on coccyx area observed area which had a scab over it - removed the scab and note no open skin under the scab...previous open area healed with firm but fluctuate area remaining. Continue to protect area with foam dressing. Watch for reoccurrence."</p> <p>A Physician Telephone Order, dated 4/2/14 and signed by the PA on 4/8/14, documented an</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>order, "Stage II ulcer in coccyx area no longer open - will continue to monitor daily, clean with NS [normal saline] and apply Mepilex until resolved. Notify MD if any complications.</p> <p>The April 2014 TAR, documented the pressure ulcer had reopened with measurements on the following dates:</p> <ul style="list-style-type: none"> * 4/4/14 - 3 x 3 cm * 4/9/14 - 3 x 3 cm * 4/11/14 - 3 x 3 cm * 4/16/14 - .7 x .5 cm * 4/23/14 - 0.3 x 0.6 cm <p>NOTE: The first NN which documented the pressure ulcer on the coccyx had reopened was dated 4/15/14.</p> <p>The resident was observed by the surveyor to be on her back as follows:</p> <ul style="list-style-type: none"> *4/22/14 from 7:45 AM to 9:20 AM; 3:50 PM; *4/23/14 at 10:30 AM; 11:35 AM; 1:00 PM; and 5:00 PM. <p>On 4/22/14 at 9:20 AM, LN #2 was observed by the surveyor during the dressing change of the coccyx pressure ulcer. She stated the wound, which contained a yellow center, had been measured yesterday and thought it measured approximately .4 x .3 cm. The surveyor and LN #2 observed a pinpoint opening above the first opening.</p> <p>NOTE: The TAR documented the wound was scheduled to be measured on 4/23/14 and did not contain a measurement dated 4/21/14. However, there was a measurement found on the TAR dated 4/23/14.</p>	F 314		

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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 04/25/2014
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)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 17</p> <p>The April 2014 Behavior Data Sheet, documented for the 21 days in April the resident was resistive to cares for turning 2 of 21 day shifts, 0 of 21 evening shifts and 10 of 21 night shifts.</p> <p>On 4/24/14 at 4:40 PM, the DNS was interviewed. When asked if the facility filled out skin assessment sheets for Resident #3, the DNS stated they used the TAR for documentation. The DNS provided a time line regarding the Stage II pressure ulcer on the coccyx. She stated the pressure ulcer could have been related to a shingles outbreak the resident experienced the end of January 2014, or it could be attributed to the resident's fall on 3/1/14. The surveyor asked the DNS to provide documentation of the shingles outbreak on the coccyx area, however, no documentation was provided. The DNS provided documentation the Stage II area on the coccyx was closed on 4/9/14 per the IDT (Interdisciplinary Team) note and that the 4/16/14 IDT note documented the Stage II area had reopened. She stated the resident was non-compliant, spent a lot of time in bed and wanted to die. As a result, the coccyx wound reopened.</p> <p>The facility failed to assess, monitor and implement measures to prevent a pressure ulcer on the coccyx to a resident admitted without a pressure ulcer. On 3/27/14, the resident's pressure/skin care plan documented an intervention to keep the resident off her coccyx as much as possible, which was 23 days after a pressure ulcer had opened. The care plan failed to give direction on how staff would keep the resident off her coccyx. The facility failed to implement the pressure/skin care plan intervention and did not monitor, assess or</p>	F 314			

Cynthia M. Ruedel 5/19/14

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F 314	<p>Continued From page 18</p> <p>prevent the resident from laying on her coccyx as observed on 4/22 - 4/23/14. The medical record did not document the risks and benefits of repositioning had been discussed with the resident.</p> <p>Documentation on the TAR did not specify which measurements were length and which ones were width. Additionally, there was no documentation of the depth, characteristics or surrounding tissues, or pain with dressing changes on the TAR.</p> <p>2. Resident #7 was admitted to the facility on 4/9/13 and readmitted on 3/31/14 with multiple diagnoses of chronic kidney disease Stage III, congestive heart failure, difficulty in walking and depression.</p> <p>Resident #7 was admitted to the facility with treatments/wound care orders, dated 3/31/14, for "heel protectors prn."</p> <p>The Skin Assessment Sheet on admission, dated 3/31/14, documented on a plain sheet of paper a body outline of multiple bruises, a dry calloused area and a scab. However, there was no documentation of a bruise to the resident's heels.</p> <p>A Braden Scale-For Predicting Pressure Sore Risk, dated 3/31/14, documented a score of 13 which indicated the resident was at moderate risk for developing pressure ulcers.</p> <p>The skin at risk care plan developed on admission did not document the use of heel protectors prn as ordered on the admission orders or to float the resident's heels. The care plan developed after admission did not document a skin at risk care plan.</p>	F 314		

Cynthia M. Reedie Adm 5/19/14

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F 314	Continued From page 19 On 4/9/14, a Condition Change Form documented, "bruise to right heel, measures 1.2 x 1.2 cm - raised, painful when palpated." On 4/9/14, ten days after admission to the facility, the chart documented a Physician Telephone Order, "Bruise to right heel, measures 1.2 x 1.2 cm. Monitor and measure weekly - notify MD if complications." On 4/9/14 a care plan update form was filled out for the problem, "bruise to right heel." On 4/11/14 the WOCN documented she saw the resident's right heel as requested since it had worsened. She documented measurements of 1.7 x 1.8 cm and was a purple blister. She recommended to paint the heel with skin prep daily and to wear heelbow protectors at all times until sage boot obtained and to wear it at all times. NOTE: The WOCN did not stage the pressure ulcer. On 4/23/14 at 11:50 AM, the surveyor observed LN #2 examining Resident #7's right heel. Heel protectors was observed on heels bilaterally and were floated on a pillow. The blister was still purple in color but was resolving and measured 2.5 cm Length x 3 cm Width. LN #2 stated the blister was looking much better and applied the skin prep as ordered. The resident denied pain when skin prep was applied. The TAR documented the right heel was measured weekly since it was found on 4/9/14.	F 314			

*Cynthia M. Rude 5/19/14
Adm*

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F 314	<p>Continued From page 20</p> <p>On 4/24/15 at 3:05 PM, the DNS was interviewed and admitted Resident #7 developed a Stage II pressure ulcer to the right heel after admission. When shown the admission order for heel protectors prn, the DNS admitted the resident should have worn heel protectors on admission. The DNS provided a care plan for skin issues with an initial date of 4/23/14.</p> <p>The facility failed to follow the admission orders to protect Resident #7's heels and the resident developed a Stage II pressure ulcer to the right heel.</p> <p>On 4/24/14 at 4:15 PM, the Administrator and DNS were made aware of the pressure ulcers concerns. The facility faxed additional information which did not resolve the issue.</p> <p>3. Resident #8 was admitted to the facility on 2/6/14 with diagnoses which included sleep apnea, abnormality of gait and gout.</p> <p>The resident's 2/20/14 Care Plan for skin documented in the intervention section the resident was to wear heel protectors and to make sure his feet were "on pillow (floated) when I am in bed."</p> <p>The Treatment Sheets (TARS) from February</p>	F 314		

*Cynthia M. Ruedel 5/19/14
Adm*

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F 314 Continued From page 21
2014 through April 2014 documented the heels were to be floated at night. The TARS did not state to float the resident's feet any time he was in bed.

On 4/23/14 at 4:10 p.m. the resident was observed in bed with heel protectors on but his feet were not floated on a pillow.

The Administrator, DON and the RSD were informed of the concerns on 4/25/14 at 12:50 p.m. The facility provided no further information.

F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, it was determined the facility failed to ensure it maintained a medication error rate less than 5 percent. This was true for 4 of 34 medications (11 percent) observed and affected 2 of 5 random residents (#13 and #14) during medication pass observations. This failed practice created the potential for an increase in blood glucose levels, inadequate pain control and for inadequate or less than optimum benefit from the prescribed medications. Findings included:

1. On 4/23/14 at 4:25 PM, Resident #13's blood glucose level was 283. LN #3 was observed to administer, using a Flex Pin of NovoLog 100 Units/ml, 6 Units subcutaneous to the right side of

F 314

F-332

This facility will ensure that it maintains a medication error rate of less than 5 percent.

All residents who receive medications at this facility have the potential to be affected.

Systemic change will include that nurses making medication errors will be asked to attend safety committee meetings to review for needed changes to medication storage, medication orders, understanding of MAR/TAR wording, work load, need for education etc.

5/19/14

Cynthia M. Reed Adm 5/19/14

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F 332	<p>Continued From page 22</p> <p>the resident's abdomen about 3 inches from the umbilicus. Additionally, on 4/23/14 at 4:55 PM, LN #3 was observed to administer one tablet of Tramadol HCL 50 mg scheduled for 3:00 PM to Resident #13.</p> <p>On 4/24/14 at 9:30 AM, Resident #13's physician orders, with a start date of 4/23/14 were reviewed. The orders documented the resident should have received 8 Units of Novolog for a blood glucose level of 250 or above. The orders documented Resident #13 should receive Tramadol HCL 50 mg one tablet every 4 hours beginning at 4:00 AM, 7:00 AM, 11:00 AM, 3:00 PM, 7:00 PM, and 11:00 PM.</p> <p>Note: 11:00 PM to 4:00 AM would be 5 hours and 4:00 AM to 7:00 AM would be 3 hours.</p> <p>On 4/24/14 at 4:15 PM, LN #4 was interviewed and stated she understood she gave the incorrect dosage for Novolog and had reviewed the MAR and it clearly stated she should have given 8 Units. LN #4 stated she knew the Tramadol should have been given earlier than she gave it, however, she gave it as soon as she was able.</p> <p>2. During a medication pass observation on 4/24/14 at 8:30 AM, LN #4 was observed to administer the following medications to Resident #14 along with her morning scheduled medications:</p> <p>*Omeprazole 20 mg one capsule. The medication label documented to take one tab by mouth every morning and to take before food/meal. Marked on the card with a black marker were the times of 7:00 AM and 5 PM.</p> <p>*Levothyroxine Sodium 125 mcg (microgram) tablet. The medication label documented to take</p>	F 332	<p>All licensed nurses will participate with medication pass auditing and educations. (see exhibit Med pass audit and Med pass review form)</p> <p>MAR will be updated to include directions for levothyroxine to be given ½ to 1 hour before breakfast on empty stomach or if resident has slept in past breakfast and/or nurse unable to administer medication before eating medication is to be given 2 hours after eating.</p>	

Cynthia M. Ruel

5/19/14

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F 332 Continued From page 23
one tab by mouth every morning on an empty stomach with plenty of water. Marked on the card with a black marker was the time 0600 (6:00 AM).

On 4/24/14 at 8:30 AM, after Resident #14 had taken her medications, the resident stated to the surveyor she had eaten breakfast.

On 4/24/14 at 8:35 AM, LN #4 stated she knew Levothyroxine should be given on an empty stomach. She stated the night shift should have given the Levothyroxine and it should have been given at 6:00 AM. She stated the night shift occasionally gives it but on the three days per week that she works she mainly has to give it on day shift. LN #4 also stated she understood Omeprazole should be given on an empty stomach and it was timed on the MAR for 7:00 AM.

Review of Resident #14's admission orders, dated 4/10/14, included an order for Levothyroxine to be given at 6:00 AM. There was also an order dated 4/21/14 for Omeprazole 20 mg po (by mouth) BID (twice daily).

The Nursing 2013 Drug Handbook states:
*Levothyroxine - Oral Administration: "Give drug at same time on each day on an empty stomach, preferably 1/2 to 1 hour before breakfast." Patient Teaching: "...Take drug at same time each morning preferably 1/2 to 1 hour before breakfast to maintain constant hormone levels and help prevent insomnia."
*Omeprazole - Oral Administration: "Give drug at least 1 hour before meals."

On 4/24/14 at 4:15 PM, the Administrator and

F 332 Omeprazole instructions will include give at least 1 hour before meals, those residents who continue to prefer that there medications are given with foods will have clarification signed by physician stating such.

Medication Pass of all nurses will take place with subsequent weeks to include 4 nurses weekly will be monitored by the DON, MDS nurse and medical records nurse.

This will be monitored weekly x 4 weeks,
every 2 weeks x 4 weeks
Monthly x 3.

1. Corrective actions will be completed by May 19, 2014

*start date of audits
5/19/14*

Cynthia M. Reed Adm 5/19/14

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F 332	Continued From page 24 DNS were made aware of the issues with the medication pass observation. The facility did not provide any further information.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure soup and salad bowls were maintained in a cleanable sanitary condition. This had the potential to affect 11 of 11 sampled residents (#s 1-11) and any other resident who ate their meals in the facility. This created the potential for cross-contamination of food and exposed residents to potential sources of pathogens. Findings included: On 4/21/14 at 1:15 PM, during the initial tour of the kitchen with the Dietary Manager (DM) in attendance, 13 out of 13 plastic soup bowls were observed to be pitted and cracked around the side of the bowls. The Dietary Manager confirmed the bowls were pitted and stated she would go through all the bowls and order replacements. She stated she	F 371	F371 All multi use food contact surfaces shall be smooth , free of breaks, open seams, cracks, chips inclusions, pits and similar imperfections Facility replaced all pitted bowls. All other multi use surfaces were inspected. Melamine bowls with non scratch surface ordered and anticipated to be delivered within 2 weeks. Dietary manager will audit bowls and plastic dishwear weekly x 4 weeks, every 2 weeks x 4 weeks RD Audits Monthly x 3. Start date 3-19-14 if audits	

5/19/14

Cynthia M. Reed

5/19/14

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F 371 Continued From page 25
kept a case of bowls in storage and would replace them as soon as possible.

The 2009 FDA Food Code chapter 4 Equipment, Utensils, and Linens, Subpart 4-202 Cleanability documented, "4-202.11 Food-Contact Surfaces. (A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections..."

F 371

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

F 431

F-431

This facility will ensure that medications will be accurately labeled.

Corrective action for resident # 15 has had new order to clarify correct instructions for use of timolol eye drops. Tramadol BID medication card was delivered, with updated label and is in use.

5/19/14

Cynthia M. Rudel 5/19/14
Adm

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Continued From page 26

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined the facility failed to ensure that medications were accurately labeled. This was the case for 2 of 5 random residents (#14 and #15) reviewed during medication pass. This created the potential that medications would be given incorrectly. Findings include:

1. On 4/23/14 at 3:55 PM, LN #3 was observed to give Resident #15 Dorzolamide-Timolol 2% - 0.5 drops in each eye, however, before giving the eye-drops she and the surveyor observed the label on the eye medication bottle to read, "Instill 1 drop in left eye everyday." LN #3 stated she normally gave one drop in each eye. The April 2014 MAR documented the resident receive "1 GTT (drop) in each eye." The Recap orders for April 2014 documented, "1 GTT in each eye with a start date of 12/12/11."
2. On 4/23/14 at 3:55 PM, LN #3 was observed to give Resident #15 a Tramadol HCL 50 mg tablet. The medication label documented to give one tab by mouth every 6 hours as

F 431

Resident # 14 omeprazole BID medication cards were delivered with updated instructions and are in use.

All residents of this facility who have medication order changes during mid-cycle fill from pharmacy have the potential to be affected.

Systemic change will include that all medications received from pharmacy during the month will have verification of new medication label to written order on MAR/TAR before being used.

This will be monitored by DON, desk nurse,

Cynthia M. Ruedel 5/19/14 Adm

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F 431 Continued From page 27
needed for pain. LN #3 stated the resident had a new Tramadol order and was now taking Tramadol BID (twice daily) and the medication needed a new label. The Recap orders for April 2014 documented, "Tramadol 50 mg by mouth twice daily" with a start date of 3/15/14.

3. On 4/24/14 at 8:30 AM, LN #4 was observed to give Resident #14 a Omeprazole 20 mg capsule. The label documented to give one cap by mouth every morning. LN #4 stated the resident had a new order for Omeprazole 20 mg BID (twice daily). She stated they had two medication cards of Omeprazole but the new card only contained 5 tablets. She stated the facility had been told by the pharmacy they would need to finish the previous medication card. As a result, the facility was only given 5 tablets of the new order and she would need to use medication from each card to finish the month. The physician order dated 4/21/14, documented, "Omeprazole 20 mg PO (by mouth) BID."

F 431 medication nurse and/or medical records nurse.

10 deliveries of medications will be monitored weekly for the first 4 weeks, every 2 weeks, monthly for three months.

Start date of audits will begin May 19, 2014

Corrective actions will be completed by May 19, 2014

F 458 SS=B 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT

Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined the facility did not ensure that 2 of 2

F 458

*Cynthia M. Reedie 5/19/14
Adm*

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F 458 Continued From page 28
multi-resident rooms #2 South (S) and 4 S provided at least 80 square feet (sq. ft.) of usable space per resident. Each of these rooms were licensed and certified for three beds. Findings included:

During a tour of the facility on 4/21/14 at 3:00 p.m., it was observed rooms 4 S had two residents in the room. Room 2 S was used as a conference room but based on an interview with the Administrator on 4/24/14 at 4:00 pm, was being retained on the State License as a 3 bed room. The Administrator stated the corporate office wanted the facility to maintain the licensed beds at 60, which equated to room 2 S and 4 S remaining available as 3 bed units.

The measurement of the rooms were as follows:
* 2 S - 239.59 sq. ft.
* 4 S - 238.23 sq. ft.

The total measurement of each room did not meet the required minimum of 240 square feet, or 80 square feet per resident.

During the end of day meeting on 4/24/14 at 5:00 p.m., the Administrator indicated the rooms would remain with two beds only, but she intended to request a waiver for the rooms to meet the 60 bed licensing agreement. On 4/28/14 the Administrator notified the Bureau of Facility Standards the corporate office had decided not to request that rooms 2 S and 4 S be licensed and certified for 3 residents.

F 458
F458

The facility will ensure that each resident is provided 80 sq feet of usable space per resident. The facility will reduce licensed beds to 58 rooms . 2S and 4S will certify for 2 residents each .

5/19/14

Cynthia M. Reedil 5/19/14
Adm

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 04/25/2014
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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
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, BSW, LSW, QIPD Rebecca Thomas, RN</p> <p>RSD - Resident Service Director</p>	C 000		
C 325	<p>02.107.08 FOOD SANITATION</p> <p>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)." This Rule is not met as evidenced by: Please refer to F-371 as it refers to sanitary conditions.</p>	C 325	Please refer to F Tag 371 Plan of correction	
C 405	<p>02.120.05,e Meets Room Dimension Requirements</p> <p>e. Patient/resident rooms shall be of sufficient size to allow not less than eighty (80) square feet of usable floor space per patient/resident in multiple-bed rooms. Private rooms shall have not less than one hundred (100) square feet of usable floor</p>	C 405	Please refer to F Tag 458 Plan of correction	

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FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Cynthia M. Ruedel</i>	<i>S Adm</i>	<i>5/19/14</i>

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 04/25/2014
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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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C 405	Continued From page 1 space. This Rule is not met as evidenced by: Please refer to F458 as it related to the room size of rooms.	C 405		
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 for revision of care plans	C 782	Please refer to F Tag 280 Plan of correction	
C 784	02.200,03,b Resident Needs Identified b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F 309 as it related to residents highest practicable physical, mental, and psychosocial well being.	C 784	Please refer to F Tag 309 Plan of correction	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F-314 as it relates to pressure	C 789	Please refer to F Tag 314 Plan of correction	

Cynthia M. Reedil *Adm* *5/19/14*

Bureau of Facility Standards

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C 789	Continued From page 2 ulcers.	C 789		
C 811	02.200,04,g,vii Medication Errors Reported to Physician vii. Medication errors (which shall be reported to the charge nurse and attending physician. This Rule is not met as evidenced by: Please refer to F-332 as it relates to medication errors.	C 811	Please refer to F Tag 332 Plan of correction	
C 832	02.201,02,f Labeling of Medications/Containers f. All medications shall be labeled with the original prescription legend including the name and address of the pharmacy, patient's/resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) This Rule is not met as evidenced by: Please refer to F-431 as it pertains to medication labels.	C 832	Please refer to F Tag 431 Plan of correction	

Cynthia M. Ruedel Adm 5/19/14