



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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P.O. Box 83720  
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November 10, 2016

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

Provider #: 135089

Dear Ms. Riedel:

On **October 21, 2016**, 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 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. 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 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 **November 21, 2016**. Failure to submit an acceptable PoC by **November 21, 2016**, may result in the imposition of penalties by **December 13, 2016**.

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*.

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 **November 25, 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 **January 19, 2017**. A change in the seriousness of the deficiencies on **December 5, 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 **January 19, 2017** includes the following:

Denial of payment for new admissions effective **January 19, 2017**. [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 **April 19, 2017**, 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 **January 19, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 **November 21, 2016**. If your request for informal dispute resolution is received after **November 21, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (L.S.W.)".

Nina Sanderson, Supervisor  
Long Term Care

NS/lj

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

PRINTED: 03/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>DESERT VIEW CARE CENTER OF BUHL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 SPRAGUE AVENUE BUHL, ID 83316</b>		
(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 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from October 17, 2016, to October 21, 2016.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, BSW, LSW, Team Coordinator Haley Young, LBSW Theresa Griggs, RN</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process.</p> <p>Survey Definitions: ADL = Activities of Daily Living AMA = Against Medical Advice BID = Twice a Day CHF = Congestive Heart Failure CNA = Certified Nursing Assistant DM = Diabetes Mellitus DNR = Do Not Resuscitate DON = Director of Nursing LN = Licensed Nurse LPM = Liters Per Minute MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram NC = Nasal Cannula O2 = Oxygen PO = By Mouth POST = Physician's Orders for Scope of Treatment PRN = As Needed RNA = Restorative Nursing Assistant</p>	F 000			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		11/25/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/22/2016

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 253	<p>Continued From page 1</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure adequate housekeeping and maintenance services were provided to ensure the residents' environment was sanitary, orderly and comfortable. This created the potential for harm if residents became embarrassed by the lack of clean surrounding and/or experienced adverse health events due to unsanitary conditions in the facility. Findings include:</p> <p>During an observation on 10/17/16 at 3:30 pm, the exit door on the east hall had a gap in the left bottom corner approximately 4 x 3 inches.</p> <p>During an observation on 10/18/16 at 12:36 pm, 2 wingback chairs in the east hall dining room had dried liquid and food on the arms and legs. There were drips of liquid down the legs of both chairs. Three cloth chairs used in the east hall dining room were stained/discolored on the seat of the chairs. One cloth chair in the main dining room was stained and discolored on the seat of the chair.</p> <p>During an observation on 10/19/16 at 9:15 am, the shower chair in the south hall shower room had dried feces on the seat. The Maintenance Supervisor, who also supervised housekeeping staff, stated during an interview on 10/19/16 at</p>	F 253	<p>The facility will provide housekeeping and maintenance services necessary to maintain a sanitary , orderly and comfortable interior.</p> <p>All residents of the facility have the potential to be effected by this concern.</p> <p>Maintenance supervisor replaced the sweep on the bottom of the east hall door.</p> <p>Maintenance supervisor inspected all doors in the facility for any issues . All doors are in compliance.</p> <p>Inservice 11/10/16 11/25/16 all staff in serviced reporting gaps on doors on a maintenance request form .</p> <p>Maintenance supervisor will audit monthly x 1 year all doors in the facility and replace any issues of the doors or sweeps of doors.</p> <p>Maintenance will provide any issues to the monthly QAPI.</p>		

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F 253	Continued From page 2 9:15 am, the bariatric shower chair was used throughout the building. According to the Maintenance Supervisor, the shower room had not been used that morning and the chair should have been clean. The Maintenance Supervisor stated the chair should have been cleaned after each use. In addition, the toilet seat in the west hall shower room had dried feces around the inside rim. According to the Maintenance Supervisor, this shower room had not been used that morning and staff should have cleaned the toilet after it was used.  During an interview on 10/19/16 at 9:30 am, the Maintenance Supervisor said he was aware of the gap in the door on the east hall to the smoking area. He said it needed a new door sweep to prevent rodents and insects from coming into the building. He said the shower chairs should be cleaned between each resident. He also said the stained cloth chairs were not to be used in either dining room and the staff should use the vinyl chairs for meals. He said housekeeping was responsible for cleaning the wingback chairs in the east hall dining room and they should be cleaned every day.  During an observation on 10/20/16 at 1:25 pm, the 2 wing backed chairs in the east hall dining room were still unclean. The chairs were unchanged from the observation on 10/18/16. The same food and fluid stains were observed on the chairs on 10/18/16 and 10/20/16.	F 253	All staff in service 11/10/16 , 11/25/16. All dining chairs need to be cleaned after each meal and PRN . Bath aide to clean shower chairs between each use. Housekeepers are to clean toilets each day and PRN . C N A S to report to housekeepers if additional cleaning is needed through out the day  Wingback chairs were cleaned . Cloth chairs were replaced throughout the facility with chairs that have cleanable surfaces .( 25 Chairs)  Supervisor/ housekeepers will clean wingback chairs and chairs daily and PRN.  Housekeeping Supervisor will audit chairs/ toilets , bath chairs for cleanliness  weekly x 4 weeks biweekly x 2 monthly q month x 9 months  auditing and education will increase in frequency if needed until compliance is maintained  Any audit issues will be reviewed at the monthly QAPI.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		11/16/16	

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F 280	<p>Continued From page 3</p> <p>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 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure care plans for 1 of 9 (#2) residents whose care plans were reviewed, were updated to reflect the resident's current code status and the use of a therapeutic hand orthosis. This had the potential to result in harm if the resident did not receive appropriate care due to lack of direction in the care plan. Findings include:</p> <p>Resident #2 was admitted to the facility on 5/8/07, with multiple diagnoses, including hand contracture and muscle wasting and atrophy.</p> <p>a. Resident #2's Quality of Life care plan, dated</p>	F 280	<p>The facility will ensure care plans are updated to reflect the resident's current code status and the therapeutic hand orthosis.</p> <p>All residents have to potential to be affected by the accuracy of the code status on the care plan</p> <p>All residents who have ordered orthotic apparatus have to potential to be affected by this practice.</p> <p>Staff education on 11/10/16 regarding the accuracy of the care plan to reflect the Idaho Post form; provided</p>		

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F 280	<p>Continued From page 4</p> <p>8/3/12, documented his code status was a full code with aggressive interventions for life-saving measures.</p> <p>Resident #2's Idaho POST, dated 7/29/14, documented his code status was a DNR and he did not want heroic or life-saving measures.</p> <p>Resident #2's current facesheet and chart sticker documented his code status was DNR.</p> <p>On 10/19/16 at 2:25 pm, LN #1 said she could look for Resident #2's code status on the chart sticker, the facesheet, the POST, and the care plan.</p> <p>On 10/19/16 at 4:30 pm, the MDS Coordinator said Resident #2's code status on the care plan was incorrect and should have read DNR.</p> <p>b. Resident #2's Occupational Therapy record, dated 8/28/14, documented he was to use a "carrot" [a hand orthosis shaped like a carrot] in his right hand due to a contracture.</p> <p>Resident #2's Restorative program flow record, dated 1/15/16, documented he used a carrot for a hand contracture.</p> <p>Resident #2's 2/9/16 annual, and 8/9/16 quarterly, MDS assessments documented he had an upper extremity contracture.</p> <p>Resident #2's current care plan did not include Resident #2's use of a therapeutic hand carrot.</p> <p>On 10/17/16 at 3:10 pm and 4:10 pm, and 10/18/16 at 1:35 pm, Resident #2 was observed</p>	F 280	<p>education to the accuracy of the charting of the orthothic apparatus.</p> <p>Resident #2 Care Plan was updated to his current Code Status</p> <p>All residents Care plans were audited for accuracy of the Care plan to reflect the Idaho Post Form.</p> <p>Care plans will be audited to assure they reflect the current Idaho Post form . This audit will be done by the IDT Team weekly for the care plans reviewed that week.</p> <p>9 charts weekly x 4 weeks 8 charts bi weekly x 2 months 4 charts 2 month x 9 months</p> <p>Auditing and education will increase in frequency if needed until compliance is maintained.</p> <p>Issues with the accuracy of audits will be brought to the monthly QAPI for review.</p> <p>Resident #2 Care Plan was updated to include the use of a therapeutic hand carrot.</p> <p>All residents care plans , who had therapeutic orthosis , were reviewed to assure their plans were accurate.</p>		

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F 280	Continued From page 5 in his bed with a therapeutic carrot in his right hand.  On 10/19/16 at 10:35 am, Resident #2 said he used the carrot off and on during the day, but was unaware of when staff were to offer it to him.  On 10/19/16 at 10:40 am, CNA #2 said the RNA placed the carrot in Resident #2's hand and she also placed it if Resident #2 asked her to.  On 10/19/16 at 11:05 am, RNA #1 said RNAs or CNAs could place the carrot in Resident #2's hand and said the care plan did not include use of the therapeutic hand carrot.	F 280	Audits will be completed on all residents with therapeutic orthosis apparatus by the IDT Team.  Monthly x 3 months Semi Monthly x 6 months quarterly x 1 quarter  All issues of audits will be brought to monthly QAPI.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to adhere to nursing standards of practice when administering medications. This was true for 1 of 9 (#4) sampled residents when LN #2 pre-poured a medication prior to the scheduled time of administration. This failure had the potential for harm related to medication errors if residents did not receive correct medications as ordered. Findings include:  Resident #4 was admitted to the facility on 3/29/16 and had physician orders that directed staff to provide hydrocodone 10/325 mg three	F 281	F226 Facility will ensure the investigation of misappropriation of a resident's property is conducted consistent with the facilities policies .  Resident's #4 did not have misappropriation of belongings  Any residents with control substance has the potential to be affected by this practice.  All - Staff was in serviced on 11/10/16	11/25/16	

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F 281	<p>Continued From page 6 times daily.</p> <p>On 10/20/16 at 1:50 pm, with the medication nurse present, it was discovered there was one tablet missing from Resident #4's medication cart supply of hydrocodone.</p> <p>On 10/20/16 at 1:55 pm, LN #2 said she administered Resident #4's scheduled morning- and 12:30 pm doses of hydrocodone. LN #2 stated Resident #4 did not have a PRN order for the hydrocodone and that the resident's hydrocodone count at the beginning of the shift was correct.</p> <p>On 10/20/16 at 3:35 pm, the DON said surveillance cameras stationed in hallways and common areas on 10/20/16 recorded LN #2 removing two hydrocodone pills from Resident #4's blister pack, which she then placed into two separate pill cups. LN #2 put one cup into the top drawer of the medication cart and took the second cup with the medication into the main dining room, where the hydrocodone was administered to Resident #4. The DON said she could not determine from the surveillance footage what happened to the second cup with the hydrocodone tablet.</p> <p>Nursing Interventions &amp; Clinical's Skills, 3rd ed., by Elkin, Perry, and Potter (p.420) documented, "Give medications within 30 minutes before or after the scheduled time to maintain a therapeutic level. Administer only those medications you personally prepare. Tablets and capsules should be kept in their wrappers and opened at the client's bedside."</p>	F 281	<p>on suspending staff for investigation of suspected abuse</p> <p>Licensed Nursing meeting on 10-27-16 was in-serviced on suspending staff for investigation</p> <p>Facility will continue to in <input type="checkbox"/> service staff on the abuse policy and procedures. If a staff person is accused of abuse neglect or misappropriation of resident property they will be suspended during the investigation .</p> <p>The control count at shift change will be correct . The control count procedure was expanded to include visual observation of pill and control number by both nurses.</p> <p>For an incorrect count that cannot be reconciled, the out-going licensed nurse may not leave until</p> <ol style="list-style-type: none"> <li>the pharmacist on call has been notified of the discrepancy;</li> <li>The administrator has been notified of the discrepancy;</li> <li>An incident report has been completed and signed by both the out going and on coming licensed nurses responsible for the controlled substances; and</li> <li>The administrative nurse on call, administrator or designee permits the out going licensed nurse to leave.</li> <li>The nurse will be suspended from work until the ongoing investigation is completed .</li> </ol>		

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F 281	Continued From page 7	F 281	The DNS/designee will complete the investigation. The Administrator / designee will audit all investigations		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident received physician ordered medications. This was true for 1 of 2 residents whose closed records were reviewed (#11). This deficient practice had the potential for harm if residents' health conditions worsened from not receiving medications as ordered. Findings include:</p> <p>Resident #11 was admitted to the facility on 3/1/16, with multiple diagnoses including CHF, diabetes mellitus and neuropathy.</p> <p>Resident #11's progress notes on 3/1/16 at 6:01 pm, documented, "Admit note: Res[ident] arrived to facility at 1530 [3:30 pm] via facility vehicle..."</p>	F 309	<p>F-309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CORRECTIVE ACTION TO BE ACCOMPLISHED</p> <p>The facility will 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.</p> <p>All new residents and/or return admissions will have medications available and administered as ordered by 11/25/2016</p> <p>Licensed nurses in-serviced 10/27/2016 that if medication is held, circled,</p>	11/25/16	

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F 309	<p>Continued From page 8</p> <p>Resident #11's 3/1/16 Admission Physician orders documented the following:</p> <ul style="list-style-type: none"> <li>-Carvedilol tablet 25 MG PO with food BID for CHF</li> <li>-Glimepiride (Amaryl) 4 MG PO BID for DM</li> <li>-Nortriptyline (Pamelor) 25 MG PO BID for Neuropathy</li> <li>-Sotalol tablet (Betapace) 120 MG PO BID for CHF</li> <li>-Metformin (Glucophage) 1000 MG PO every evening for DM</li> </ul> <p>Resident #11's 3/1/16 MAR documented he was to receive the Carvedilol, Glimepiride, Nortriptyline, Sotalol and Metformin at 5:00 pm. Next to each medication were circled initials, indicating the medications were not given.</p> <p>Resident #11's 3/1/16 Physician's Telephone Order documented, "OK to use med[ication]s from home until pharmacy delivery arrives." The order did not indicate which medications the order referred to and progress notes did not reference the medication issue.</p> <p>Resident #11's Discharge Against Medical Advice form documented he was discharged on 3/1/16 at 10:15 pm.</p> <p>On 10/20/16 at 10:55 am, the DON said the circled initials on the MAR meant the medications were not given. The DON said there was no explanation in the chart indicating why the medications were not given.</p> <p>On 10/20/16 at 1:10 pm, LN #3 said she did not give the medications in question because the</p>	F 309	<p>unavailable etc please make note in the nurse notes, be sure to notify the physician if medication is unavailable for possible alternate equivalent to be used and document that family was notified.</p> <p><b>RESIDENTS WITH POTENTIAL TO BE AFFECTED:</b> All new admit residents have the potential to be affected by this practice.</p> <p><b>SYSTEMIC CHANGES:</b> Facility has changed pharmaceutical services to a closer location. March 1, 2016 Facility has installed and expanded the medications available through Medication PYXIS in facility. April 2016 Facility has changed to electronic documentation in MAR records with electronic coding and progress note prompt for reason for medication not being given. April 2016</p> <p><b>PERFORMANCE MONITORING:</b> DON or designee will monitor all new admissions for medications ordered being received.</p> <p><b>AUDIT:</b> All new admit or return admission residents will be audited upon return for all medications ordered being given each week.</p>		

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F 309	Continued From page 9 facility did not have them in the building. She said she could not find a note on the MAR or in the progress note indicating why the medications were not given.	F 309			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on staff interview, review of Incident and Accident Reports, and record review, it was determined the facility failed to ensure a hazard free environment was provided for 15 of 15 residents who resided on the east hall/behavior unit, and that 1 of 11 sampled residents (Resident #5) received sufficient supervision to prevent falls. These deficient practices placed residents on the east hall at risk of harm if they ingested harmful chemicals, and Resident #5 at risk of serious injury due to falls or unsafe smoking practices. Findings include:  1. During an observation on 10/19/16 at 9:00 am, the east hall shower door was open and a cabinet containing cleaning chemicals was unlocked. The east hall also served as the facility's behavioral unit.  The label of one of cleaning chemical	F 323	F-323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CORRECTIVE ACTION TO BE ACCOMPLISHED The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident will receive adequate supervision and assistance devices to prevent accidents. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents of facility have potential to be affected by chemicals being unlocked in cabinets. All residents of facility have potential of fall. Investigation of fall indicates that resident #5 was not smoking at time of fall in smoke area . All residents with extensive assistance will not be unattended in smoke area.	11/25/16	

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F 323	<p>Continued From page 10 (TrueKleen) included, "caution - may cause eye and skin irritation." The label of the second cleaning chemical (GM Disinfectant Cleaner) indicated it could "cause infection if in contact with open wounds."</p> <p>During an interview on 10/19/16 at 9:05 am, LN #1 said the door to the shower room should be closed and the cabinet should be locked. She said it was unsafe for the products to be stored in an unlocked cabinet because they could be hazardous to the residents. She said the residents could get the chemicals in their eyes, on their skin, or swallow them. LN #1 also said the residents on the east hall were more at risk because of their cognitive status and behaviors.</p> <p>During an interview on 10/19/16 at 9:10 am, the Maintenance Supervisor said any cabinet containing cleaning chemicals should be locked. He said the residents were at risk if chemicals were accessible.</p> <p>2. Review of the Physician's Orders, dated October 2016, indicated Resident #5 was admitted on 1/22/15 with diagnoses that included: intracranial brain injury, intermittent explosive disorder, dysphagia, unspecified psychosis, epilepsy and cerebrovascular accident (stroke) with right arm paresis.</p> <p>Resident #5's MDS assessment, dated 9/26/16, documented his cognition was severely impaired. The assessment stated Resident #5 required extensive one person assistance to complete activities of daily living (ADLs).</p> <p>Resident #5's care plan, dated 8/5/16,</p>	F 323	<p><b>SYSTEMIC CHANGES:</b> Staff in-service written in-service was conducted on 10/27/2016 to review F 323 accidents and supervision. This was reviewed again on 11/10/2016 at in-service. Lock on chemical cabinet was replaced on 10/19/2016 by Maintenance Supervisor. In-service to all staff for locked chemicals was held at in-service 11/10/2016 Resident #5 will be moved to first smoke time to decrease his anticipation of smoke times. 11/22/2016 Door alarm to be installed to smoke area to alert staff to any resident going to smoke area unattended. 11/25/2016 <b>PERFORMANCE MONITORING:</b> Check list is placed in each bathroom cabinet for random review audit checks that chemicals are locked are in place. Random checks of door alarm being turned on will be conducted Random checks of residents with extensive assistance unattended in smoke area will be conducted. <b>AUDIT:</b> DON or designee will complete 5 random audits of chemicals being locked per week x 4 weeks; then 5 random audits biweekly x 2 months; then 5 random audits monthly x 9 months. DON or designee will complete 5 random audits of door alarm to smoke area being on/functioning per week x 4 weeks; then 5 random audits biweekly x 2 months; then 5 random audits monthly x 9 months DON or designee will complete 5 random</p>		

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F 323	<p>Continued From page 11</p> <p>documented Resident #5, "was a smoker and did not know when he was going to get hurt." The care plan also stated staff were to supervise Resident #5 during smoke time and hold his cigarette for him with an extender because he was not safe to smoke on his own. Resident #5's care plan stated he may get up and try to walk so he was on 15 minute checks.</p> <p>A Nurse's Note," dated 10/12/16, documented Resident #5 had an unwitnessed fall. It documented Resident #5 self-propelled his wheel chair into the outside smoking area. Resident #5 was found in the grass in a seated position with his wheelchair upright next to him. No injuries were noted after the fall.</p> <p>An incident report, dated 10/13/16, documented Resident #5 had an unwitnessed fall outside in the smoking area. Staff determined the cause of the fall to be "resident disregard of physical limitations." The report also stated Resident #5 was not supervised at the time of the fall.</p> <p>During an interview on 10/18/16 at 3:03 pm, CNA #1 said Resident #5 needed someone to stand with him in the hall while he waited for smoke time. She said he occasionally strikes out at other residents and needs assistance with smoking. She said a staff person should assist him to the smoking area.</p> <p>During an interview on 10/19/16 at 11:55 am, CNA #2 said Resident #5 was a high fall risk and the staff checked on him often. She said Resident #5 tried to stand up at smoke time, which was unsafe, and needed 1:1 supervision for smoking.</p>	F 323	audits extensive assist residents being unattended in smoke area per week x 4 weeks; then 5 random audits biweekly x 2 months; then 5 random audits monthly x 9 months		

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F 323	Continued From page 12	F 323			
F 328 SS=D	<p>During an interview on 10/19/16 at 12:00 pm, Unit Manager (UM) #1 said Resident #5 required 15 minute checks for supervision and the staff should know where he was at all times. She said he was unable to propel himself in his wheelchair independently to the smoking area. She said a staff person should be with Resident #5 in the smoking area. UM #1 said she did not know why Resident #5 was unsupervised on the day he fell and that the staff should always accompany him to the smoke area. She said staff were not following Resident #5's plan of care, which required him to be supervised when smoking.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents who used oxygen were monitored for oxygen saturation rates. This was true for 1 of 3 sampled residents (#11) who used oxygen. The deficient practice had the potential for harm if</p>	F 328	<p>F328 The facility will ensure that oxygen will be administered as ordered.</p> <p>Resident #11 no longer resides at this facility.</p>	11/25/16	

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F 328	<p>Continued From page 13</p> <p>residents received oxygen therapy contrary to physician orders. Findings include:</p> <p>Resident #11 was admitted to the facility on 3/1/16, with multiple diagnoses including CHF.</p> <p>Resident #11's progress notes, on 3/1/16 at 6:01 pm, documented, "Admit note: Res[ident] arrived to facility at 1530 [3:30 pm] via facility vehicle...On 3 LPM continuous O2 via NC..."</p> <p>Resident #11's 3/1/16 Admission Nursing Assessment under the oxygen saturation section was blank.</p> <p>Resident #11's 3/1/16 Physician Telephone Orders documented he was to be on oxygen at 3 LPM via NC continuously, to check saturation levels each shift to maintain levels above 90%, and to notify the physician if 90% could not be maintained.</p> <p>Resident #11's 3/1/16 MAR did not document an O2 saturation level for the day or evening shift.</p> <p>On 10/20/16 at 10:55 am, the DON said saturation levels were not documented on the Admission Nursing Assessment, MAR, or progress notes.</p>	F 328	<p>The facility will not accept late night admissions from the hospital until complete review and ensure that medications and oxygen will be available.</p> <p>All residents utilizing Oxygen have the potential to be affected.</p> <p>All staff in service 11/10/16 Nurses in service 10/27/16 Regarding oxygen administration and checking saturations and charting</p> <p>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 saturation, target saturation levels, instructions of what to do if saturation falls below saturation level, what to do if saturation cannot be maintained above designated percentage and notify MD for further instructions when needed.</p> <p>All residents with oxygen orders will be monitored for concentrator , oxygen buddy, mister machine, and c-pap settings to be as ordered.</p> <p>Facility will place random auditing for compliance with oxygen being administered as ordered and MD notification be documented when saturations are not maintained .</p>		

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

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F 328	Continued From page 14	F 328	Facility will monitor 5 residents weekly x 4 weeks 5 residents bi weekly x 2 months 5 residents monthly x 9 months  Trending of audits will be reported to Monthly Qapi meeting.		
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 329		11/25/16	

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F 329	<p>Continued From page 15</p> <p>Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure 1 of 11 sampled residents (Resident #4) who received antipsychotic medication received a gradual dose reduction (GRD). Receiving higher doses of medications than may be necessary, increased the risk of residents experiencing adverse medication side effects. Findings include:</p> <p>Resident #4 was admitted on 3/29/16 with diagnoses that included: alcoholic dementia with psychosis, delusional disorder, atrial fibrillation, pain, and gastroesophageal reflux disease. She had orders to receive Depakote (used to treat Bi-polar disease) 250 milligrams (mg) twice a day and Haloperidol (an antipsychotic) 1 mg once daily.</p> <p>Resident #4's admission MDS assessment, dated 9/1/16, documented there were no problems with Resident #4's cognitive abilities. The MDS stated she exhibited verbal behaviors towards others, and other behaviors not directed towards others.</p> <p>Resident #4's care plan, dated 9/19/16, documented Resident #4 had behaviors that included physical assaults, verbal assaults, resistance to cares, delusions, hallucinations, depression, and social inappropriateness.</p> <p>A Consultation Report, dated 2/17/16, from the pharmacist indicated a GDR was recommended for Resident #4's Depakote 250 mg twice a day. The pharmacist suggested a decrease to Depakote 125 mg in the morning and 250 mg at night. The recommendation was accepted by the</p>	F 329	<p>The facility will ensure that residents who receive antipsychotic medication, receive a gradual dose reduction, when not clinically contraindicated .</p> <p>Resident #4 was reviewed on 11/7/16 with the PDR team , pharmacist and Dr. Desai. Dr. Desai stated the medication is appropriate for this resident and her quality of life and no GDR is recommended at this time</p> <p>On first admission to DVCC Resident was admitted with 5 mg Haldol BID . 9-11-13</p> <p>2-12-14 GDR Haldol from 2.5 Mg to 1 MG QD increased delusions but more alert</p> <p>9-10-14 DC Fentanyl patch successful</p> <p>2-11-15 GDR Depakote 250 mg TID down to 250 mg BID some hand tremors</p> <p>3/11/15 GDR Haldol from 1.5 mg down to 1 mg QAM Failed increased delusions , aggression</p> <p>5-/20/15 GDR Carbidopa/Levodopa to 10/100BID Successful</p>		

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F 329	<p>Continued From page 16</p> <p>physician on 2/24/16. A Consultation Report, dated 1/04/16, indicated a recommendation to reduce Resident #4's Haloperidol from 1 mg to 0.5 mg was discussed and implemented by the staff.</p> <p>A Physician Telephone Order, dated 2/26/16, discontinued the GDR for Depakote and Haloperidol.</p> <p>A Resident Services Progress Note, dated 3/1/16, indicated Resident #4's family member called the facility and said she wanted Resident #4's psychoactive medication dosages changed back to what they were prior to the GDR. The note documented the facility staff contacted the physician and he agreed to change the dosages back.</p> <p>During an interview on 10/18/16 at 2:35 pm, Resident #4 said the facility did notify her when there were changes in her medications. She said it had been a little while since any changes were made but she did recall a care plan conference a few months ago regarding changes to her medication and care.</p> <p>During an interview on 10/19/16 at 2:15 pm, the Resident Services Coordinator (RSC) said Resident #4's family was upset with the changes made to her medications. She said they felt the medications needed to be changed back to their original doses. The RSC said the staff discussed this and decided to discontinue the GDR.</p> <p>During an interview on, 10/20/16 at 10:10 am, the DNS said she remembered when Resident #4's GDR was discontinued and she recalled the</p>	F 329	<p>7-1-15 DC Sinemet start Primidone 12.5 QHS Successful</p> <p>7/15/15 GDR Haldol down to 1 mg QD Successful</p> <p>01/01/16 GDR 1 mg down to 0.5 Daughter did not feel reduction was good</p> <p>2/24/16 Pharmacy recommend to GDR Depakote down to 125 mg Q AM and keep 250 mg 1700 dose the same daughter did not feel the reduction was good and requested to be put back on Dr Marshall discussed the medical issues Dr Desai felt with increased medical issues including a fracture of the foot was not a good time for the reduction</p> <p>3/9/16 DC Gabapentin successful Dr. Desai noted that the increase bi polar symptom in the form of increased psychomotor activity increased writing of letters to the family members telling the family members that she wanted to move home and impaired judgment . IN the past when these symptoms have happened and if they have not been addressed quickly they have caused further exacerbation of her mood symptoms which then became very disabling and required major increase in psychiatric medicines . Because of the symptoms we increased back the</p>	

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F 329	<p>Continued From page 17</p> <p>family was upset by the changes to Resident #4's medication. She said the psychiatrist agreed to discontinue the GDR after 2 days due to the family's request.</p> <p>The facility's Antipsychotic Medication Use policy, dated December 2014, documented "the lowest possible doses of antipsychotic medications will be utilized. Any doses of antipsychotic medications that exceed the CMS Guidelines will have sound and comprehensive clinical documentation discussing all non-pharmacologic interventions that were attempted prior to going above the CMS Guidelines. Prior to initiating a new antipsychotic medication order or changing a current antipsychotic order the order must first be discussed with the facility's Certified Medical Director. This includes orders from all attending and on-call practitioners, including psychiatric physicians other than orders received directly from the facility's Medical Director. "</p>	F 329	<p>haloperidol from 0.5 back to 1 mg and these symptoms have settled down . She still has mild residual symptoms but overall is doing better . The patient is tolerating current medicines well. The Patient does feel that she is on a lot of medicines , but the psychiatric medicines she is taking is only two ." The assessment and treatment plan states" the patient with diagnosis of other specified bi polar disorder, is doing significantly better on Depakote 250 mg twice a day and haloperidol 1 mg daily . Thee are relatively low dose of psychiatric medicines. Benefits of these medicines outweigh the risks,. Best to manage any residual symptoms with psychosocial and environmental approaches . The patient also has alcohol use disorder and alcohol-related neurocognitive disorder mainly with executive dysfunction . I believe the increase in Haldol was clinically indicated I explained this to the team . The patient psychiatric illness is severe and we need to take the patients exacerbation of symptoms seriously At the same time I am willing to reconsider reduction of haloperidol down the line if the patient continues to improve further and respond to psycho social and environmental approaches</p> <p>All residents who receive antipsychotic medication have the same potential to be affected.</p> <p>All residents who received antipsychotic</p>		

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F 329	Continued From page 18	F 329	<p>medication were reviewed with the PDR team , Dr, Desai and the pharmacist.</p> <p>Resident #4 behaviors will be reviewed and clearer definitions of what each behavior is for Resident #4 are now included. Aides and nurses will communicate with each other to decrease conflicting documentation of behaviors. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents with behaviors and behavior tracking have potential to be affected in behavior tracking and documenting. All residents with physician ordered use of bed mobility device has the potential to be affected.</p> <p>SYSTEMIC CHANGES: All residents with behavior tracking in place were reviewed and behavior definitions of each individual's behaviors were updated. All residents Medication Review Reports were reviewed for any further missing items from orders and not in place.</p> <p>PERFORMANCE MONITORING: BEHAVIORS: All residents with known behaviors will have review on admission and weekly x 4 weeks while behavior care plan and interventions are being developed. All new admissions will be monitored weekly x 4 weeks for onset of new or unknown behaviors and interventions Residents being seen at Psychotropic</p>		

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F 329	Continued From page 19	F 329	<p>Drug Review (PDR) meeting will be charted on x 7 days prior to PDR meeting date for behaviors, refusals, meal intakes, weight loss/gain, or changes in ADLs. Residents with medication changes as a result of PDR meeting will be reviewed at behavior meeting weekly x 4 weeks to review behaviors, refusals, meal intakes, weight loss/gain or changes in ADLs. Nurse notes will be reviewed weekly for supporting documentation of behaviors charted in ADLs and/or behavior documentation.</p> <p>Behavior care plans will be reviewed and updated at least quarterly. Each review/update will have initials of reviewer and date completed.</p> <p>AUDIT: All residents with behaviors will be reviewed by 11/25/2016 and definitions of each resident's behaviors will be implemented and in-serviced by Behavior Management Team. DON or designee will audit behavior tracking and supporting documentation in nurse notes 10 residents weekly x 4 weeks; then 10 residents bi-weekly x 2 months; then 10 residents monthly x 9 months. DON or designee will audit 4 residents weekly for new orders for bed mobility apparatus and include monitoring to ensure installation of such apparatus if ordered by Therapies.</p> <p>Any concerns of audits will be brought to the monthly QAPI meeting.</p>		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		11/25/16	

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F 441 SS=E	<p>Continued From page 20 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441		

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F 441	Continued From page 21  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of clinical records and facility policies, it was determined the facility failed to ensure a) staff performed hand hygiene before and after providing incontinence care for 2 of 6 residents sampled (#6 and #12) for incontinence care, and b) staff handled and transported linens on the North Hall so as to prevent the spread of infection. These failures had the potential to affect all residents who resided on the North Hall and placed residents at risk of developing infections. Findings include:  During an observation on 10/20/16 at 8:15 am, CNA #4 performed incontinent care for Resident #6. CNA #4 did not wash her hands and change her gloves after gathering supplies from Resident #6's bedside chest and closet; and prior to performing incontinence care. After finishing CNA #4 did not remove her dirty gloves and wash her hands before leaving the room to dispose of trash in a soiled linen closet on the North hall. After disposing of the trash, with the same dirty gloves, CNA #4 entered the clean linen closet on North hall and retrieved a clean blanket for Resident #6. CNA #4 touched the dirty and clean linen door knobs, contaminating them with her soiled gloves. Also, CNA #4 contaminated the linen in the clean linen closet by wearing soiled gloves while stirring through the linen to find a blanket.  During an observation on 10/20/16 at 8:35 am, CNA #5 performed incontinence care for Resident #12. CNA #5 did not wash her hands	F 441	F-441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  Corrective Action: The facility will 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. The facility will improve the Infection Control Program including Investigating, controlling, and preventing infections in the facility The facility will decide what procedures should be applied to any individual The facility will maintain record of incidents and corrective actions to infections. The facility will prevent the spread of infection The facility will determine if resident requires isolation to prevent the spread of infection, and if the facility must isolate the resident. The facility will prohibit employees with communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional		

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F 441	<p>Continued From page 22</p> <p>and change her gloves after gathering supplies from Resident #12's closet. CNA #5 failed to wash her hands prior to providing care for Resident #12. After providing the care, CNA #5 removed her dirty gloves but did not wash her hands before leaving the room to dispose of trash in a soiled linen closet on the North Hall. After disposing of the trash into the dirty trash barrel, CNA #5 returned to Resident #12's room, repositioned him and covered him with a blanket before she washed her hands.</p> <p>During an interview on 10/20/16 at 9:42 am, the Infection Control Nurse said she was responsible for training and competency skills check-offs for CNAs. She said CNAs are taught to wash their hands upon entering a resident room and before leaving. She said she did not have a skills checklist for CNA #4 and CNA #5.</p> <p>During an interview on 10/20/16 at 9:49 am, CNA #2 said she did not remember completing a skills checklist and said a supervisor had not watched her perform incontinence care to see if she was providing care correctly.</p> <p>During an interview on 10/20/16 at 9:50 am, the DON said CNAs received training and skills check-off upon hire and annually. The DON said all staff were taught to wash their hands when they enter a resident's room and when they leave the room. Additionally, the DON stated staff were not to enter the clean linen closet with dirty gloves or dirty hands.</p> <p>A facility policy and procedure, Handwashing/Hand Hygiene, dated September 2014, stated all employees must wash their</p>	F 441	<p>practice.</p> <p>The facility will handle, store, process and transport linens so as to prevent the spread of infection. The facility will ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care or residents' needs as identified through resident assessments and described in the plan of care.</p> <p>Policy Procedure for Perineal Care will be updated to reflect that no barrier or table will be used for preparation of pericare, wash basin, towels and washcloths will not be utilized. Staff will use packaged cleansing wipes for this purpose.</p> <p>How to identify residents All residents of the facility have the potential to be affected by improper hand hygiene and safe handling and transportation of linens.</p> <p>Measures put into place: The Infection Control Nurse will complete C.N.A. pericare, handwashing and handling of soiled linen skill check for all current C.N.A.s by November 25, 2016. These will be done by demonstration and review of policy and procedures. Preceptor meeting was held to review skills check list requirements Policy and Procedure and skills check list for Perineal Care was updated and implemented on November 21, 2016. Systemic changes: The facility will audit all newly hired C.N.A.s for orientation skills check list completion and being signed by Preceptor and aide upon completion of</p>		

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F 441	Continued From page 23 hands using proper procedures and before and after direct resident contact. The policy also stated use of gloves does not replace handwashing/hand hygiene.	F 441	preceptor training. The facility policy for Preceptor bonus paid is now adjusted to be paid upon completion and return of skills check list to business office. The facility will include skills check sheets in their employee new hire packets for handwashing, pericare, and linen handling.  How to Monitor: The Infection Control Nurse or designee will monitor performance to ensure corrective actions are effective and compliance is sustained by random audits of handwashing, pericare and linen handling. Infection Control Nurse or designee will observe C.N.A. □s as follows: Week 1 audit will include all staff completion of skills check for handwashing, pericare and linen handling  Weekly x 3 weeks will include 10 C.N.A. □s being audited Bi-weekly x 8 weeks will include 10 C.N.A. □s being audited Then 10 C.N.A. □s monthly x 9 months The Infection Control Nurse will make monthly reports to QAPI meeting.		
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS  The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 498		11/25/16	

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F 498	<p>Continued From page 24 assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policies and personnel records, it was determined the facility failed to ensure CNAs were able to demonstrate competency in providing incontinence care. This was true for 2 of 11 sampled residents (#6 and #12), and had the potential to affect the 20 residents residing in the facility who were identified as incontinent. This deficient practice placed residents who required incontinence care at risk of impaired skin integrity due to inadequate washing, and at risk of contracting infections due to lack of appropriate infection control practices. Findings include:</p> <p>Staff did not demonstrate appropriate infection control practices while performing perineal care. Examples include:</p> <p>a. During an observation and interview on 10/20/16 at 8:15 am, CNA #4 performed incontinent care for Resident #6. CNA #4 did not wash her hands and change her gloves after gathering supplies from Resident #6's bedside chest and closet. CNA #4 set clean supplies (disposable brief, disposable wipes, and peri wash) on the edge of the bed. She did not place a barrier underneath the supplies. She did not wash her hands and change her gloves before providing incontinence care. After finishing, CNA #4 did not remove her dirty gloves and wash her hands before leaving the room to dispose of trash in the soiled linen closet on the North hall.</p>	F 498	<p>F-498 483.75 (f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS</p> <p>Corrective Action: The facility will 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. The facility will improve the Infection Control Program including Investigating, controlling, and preventing infections in the facility The facility will decide what procedures should be applied to any individual The facility will maintain record of incidents and corrective actions to infections. The facility will prevent the spread of infection The facility will determine if resident requires isolation to prevent the spread of infection, and if the facility must isolate the resident. The facility will prohibit employees with communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>		

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F 498	<p>Continued From page 25</p> <p>After disposing of the trash, with the same dirty gloves, CNA #4 entered the clean linen closet on North hall and retrieved a clean blanket for Resident #6. CNA #4 went back into Resident #6's room and placed the blanket over her. CNA #4 said she did not remember if she completed a competency skills check-off. She remembered the form but did not remember completing it.</p> <p>b. During an observation and interview on 10/20/16 at 8:35 am, CNA #5 performed incontinence care for Resident #12. CNA #5 did not wash her hands and change her gloves after gathering supplies from Resident #12's closet. CNA #5 set clean supplies (disposable brief and basin of water) on the edge of the bed. She did not place a barrier underneath the supplies. CNA #5 did not use soap or peri-wash to clean Resident #12. CNA #5 gathered the dirty supplies in a plastic bag. She removed her dirty gloves and did not wash her hands before leaving the room to dispose of trash in a soiled linen closet on the North hall. She returned to Resident #12's room, positioned Resident #12, then washed her hands. CNA #5 said she was an experienced CNA and she never used soap or peri-wash during incontinence care. She said she did not use soap even if a resident had feces on them. CNA #5 said she did not complete a competency skills check-off. She said she was already experienced so she just shadowed another CNA for a couple days.</p> <p>During an interview on 10/20/16 at 9:42 am, the Infection Control Nurse said CNA's were checked off on their skills upon hire and then annually. She said she did not have a skills checklist for CNA #4 and CNA #5. According to the Infection</p>	F 498	<p>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>The facility will handle, store, process and transport linens so as to prevent the spread of infection. The facility will ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs as identified through resident assessments and described in the plan of care.</p> <p>Policy Procedure for Perineal Care will be updated to reflect that no barrier or table will be used for preparation of pericare, wash basin, towels and washcloths will not be utilized. Staff will use packaged cleansing wipes for this purpose.</p> <p>How to identify residents All residents of the facility have the potential to be affected by improper hand hygiene and safe handling and transportation of linens.</p> <p>Measures put into place: The Infection Control Nurse will complete C.N.A. pericare, handwashing and handling of soiled linen skill check for all current C.N.A.'s by November 25, 2016. These will be done by demonstration and review of policy and procedures. Preceptor meeting was held to review skills check list requirements Policy and Procedure and skills check list for Perineal Care was updated and implemented on November 21, 2016. Systemic changes:</p>		

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F 498	<p>Continued From page 26</p> <p>Control Nurse, she was responsible for ensuring the checklists were complete for all new hires and annually. The Infection Control Nurse said she moved into her role in June 2016, and got behind on ensuring CNA's were proficient and were receiving competency training.</p> <p>During an interview on 10/20/16 at 9:49 am, CNA #2 said she did not remember completing a skills checklist. She said a supervisor had not watched her perform incontinent care to see if she was providing care correctly.</p> <p>During an interview on 10/20/16 at 9:50 am, the DON said the CNAs received training and skills check-off upon hire and annually. The DON said all staff were taught to wash their hands when they enter a resident's room and when they leave the room. Staff were not to enter the clean linen closet with dirty gloves or dirty hands. She said she had no idea staff were not using soap or peri-wash during incontinence care. The supplies were in the Pyxis and readily available.</p> <p>The personnel records for CNA #2, CNA #4, and CNA #5 did not include evidence of competency skills training.</p> <p>A policy and procedure titled, Perineal Care, noted:</p> <ul style="list-style-type: none"> <li>* Staff were to place equipment either on a barrier cloth or a wash table first.</li> <li>* Staff were to wet the washcloth and apply soap or skin cleansing agent.</li> </ul> <p>During an interview on 10/20/16 at 1:15 pm, the Administrator said the facility did not have a</p>	F 498	<p>The facility will audit all newly hired C.N.A. □s for orientation skills check list completion and being signed by Preceptor and aide upon completion of preceptor training.</p> <p>The facility policy for Preceptor bonus paid is now adjusted to be paid upon completion and return of skills check list to business office.</p> <p>The facility will include skills check sheets in their employee new hire packets for handwashing, pericare, and linen handling.</p> <p>How to Monitor: The Infection Control Nurse or designee will monitor performance to ensure corrective actions are effective and compliance is sustained by random audits of handwashing, pericare and linen handling. Infection Control Nurse or designee will observe C.N.A. □s as follows: Week 1 audit will include all staff completion of skills check for handwashing, pericare and linen handling</p> <ul style="list-style-type: none"> <li>Weekly x 3 weeks will include 10 C.N.A. □s being audited</li> <li>Bi-weekly x 8 weeks will include 10 C.N.A. □s being audited</li> <li>Then 10 C.N.A. □s monthly x 9 months</li> </ul> <p>The Infection Control Nurse will make monthly reports to QAPI meeting.</p>		

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F 498	Continued From page 27	F 498			
F 514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined the facility failed to ensure complete and accurate clinical records were maintained. This was true for 2 of 11 sampled residents (#2 &amp; #4). This deficient practice increased the risk for care decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</p> <p>1. Resident #2 was admitted to the facility on 5/8/07 with multiple diagnoses, including hand contracture and muscle wasting and atrophy.</p> <p>a. Resident #2's Restorative program flow record,</p>	F 514	<p>F514 483.75 (I)(1) CORRECTIVE ACTION TO BE ACCOMPLISHED</p> <p>The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record will contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Resident #2 See F-280 restorative</p>	11/25/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>DESERT VIEW CARE CENTER OF BUHL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 SPRAGUE AVENUE BUHL, ID 83316</b>		
(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 514	<p>Continued From page 28 dated 1/15/16, documented "4. Sea Breeze on my left hand, add carrot [a carrot shaped orthosis]."</p> <p>On 10/17/16 at 3:10 pm and 4:10 pm, and 10/18/16 at 1:35 pm, Resident #2 was observed in his bed with a therapeutic carrot in his right hand.</p> <p>On 10/19/16 at 10:35 am, Resident #2 said he used the carrot for his right hand contracture.</p> <p>On 10/19/16 at 11:05 am, RNA #1 said the Restorative program flow record was inaccurate and it should have documented Resident #2 used a therapeutic carrot in his right hand, not his left.</p> <p>b. Resident #2's October 2016 Medication Review Report documented an order, dated 10/28/15, of "Trapeze over bed for increased bed mobility."</p> <p>From 10/17/16 at 3:10 pm to 10/20/16, Resident #2's bed was observed multiple times without a trapeze attached to the bed.</p> <p>On 10/19/16 at 10:35 am, Resident #2 said he no longer used the trapeze and did not remember when it was discontinued.</p> <p>On 10/20/16 at 9:55 am, the Medical Records nurse said the trapeze was discontinued and she was not sure why the trapeze was still on the report.</p> <p>2. Resident #4 was admitted to the facility on 3/29/16, with diagnoses that included: dementia</p>	F 514	<p>program plan of correction for right hand orthotic apparatus and sea breeze application</p> <p>Resident #2 will be reviewed by Occupational Therapy and physician order updated to reflect the need for and use of trapeze over resident bed for increased bed mobility.</p> <p>Resident #4 behaviors will be reviewed and clearer definitions of what each behavior is for Resident #4 are now included. Aides and nurses will communicate with each other to decrease conflicting documentation of behaviors.</p> <p><b>RESIDENTS WITH POTENTIAL TO BE AFFECTED:</b></p> <p>All residents with behaviors and behavior tracking have potential to be affected in behavior tracking and documenting.</p> <p>All residents with physician ordered use of bed mobility device has the potential to be affected.</p> <p><b>SYSTEMIC CHANGES:</b></p> <p>All residents with behavior tracking in place were reviewed and behavior definitions of each individual's behaviors were updated.</p> <p>All residents Medication Review Reports were reviewed for any further missing items from orders and not in place.</p> <p><b>PERFORMANCE MONITORING: BEHAVIORS:</b></p> <p>All residents with known behaviors will have review on admission and weekly x 4 weeks while behavior care plan and interventions are being developed.</p> <p>All new admissions will be monitored</p>		

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F 514	<p>Continued From page 29</p> <p>with psychosis, delusional disorder, atrial fibrillation, pain and gastroesophageal reflux disease. She had orders to receive Depakote (used to treat Bi-polar disease) 250 milligrams (mg) twice a day and Haloperidol (an antipsychotic) 1 mg once daily.</p> <p>Resident #4's admission MDS assessment, dated 9/1/16, documented she had no cognitive deficits. The MDS stated Resident #4 exhibited negative verbal behaviors towards others and other behaviors not directed towards others.</p> <p>A Care Plan, dated 9/19/16, documented Resident #4 had behaviors that included physical assaults, verbal assaults, resistance to cares, delusions, hallucinations, depression, and social inappropriateness.</p> <p>A Behavior/Medication Monitoring Summary, dated January 2016, documented Resident #4 exhibited 28 verbal assaults to staff, 7 verbal assaults to peers, was resistive to cares/non-compliant 10 times, and engaged 35 socially inappropriate episodes. On 1/10/16 staff documented Resident #4 was "being verbal." On 1/16/16 staff documented Resident #4 complained about kitchen staff, food, and not getting pop. On 1/29/16 staff documented Resident #4 refused care from one aide and requested care from another aide.</p> <p>A Nurse's Progress Note, dated 1/10/16, documented Resident #4 was pleasant and cooperative with cares. This was the same day staff documented 35 behavior episodes. A nurse's note, dated 1/16/16, stated Resident #4 had no abnormal behaviors. However, it was</p>	F 514	<p>weekly x 4 weeks for onset of new or unknown behaviors and interventions Residents being seen at Psychotropic Drug Review (PDR) meeting will be charted on x 7 days prior to PDR meeting date for behaviors, refusals, meal intakes, weight loss/gain, or changes in ADLs.</p> <p>Residents with medication changes as a result of PDR meeting will be reviewed at behavior meeting weekly x 4 weeks to review behaviors, refusals, meal intakes, weight loss/gain or changes in ADLs.</p> <p>Nurse notes will be reviewed weekly for supporting documentation of behaviors charted in ADLs and/or behavior documentation.</p> <p>Behavior care plans will be reviewed and updated at least quarterly. Each review/update will have initials of reviewer and date completed.</p> <p>AUDIT: All residents with behaviors will be reviewed by 11/25/2016 and definitions of each resident's behaviors will be implemented and in-serviced by Behavior Management Team.</p> <p>DON or designee will audit behavior tracking and supporting documentation in nurse notes 10 residents weekly x 4 weeks; then 10 resident's bi-weekly x 2 months; then 10 resident's monthly x 9 months.</p> <p>DON or designee will audit 4 residents weekly for new orders for bed mobility apparatus and include monitoring to ensure installation of such apparatus if ordered by Therapies.</p>		

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F 514	<p>Continued From page 30</p> <p>documented that Resident #4 had 15 behavioral episodes that day. A nurse's note, dated 1/30/16, indicated Resident #4 was pleasant and cooperative with cares, however, staff documented Resident #4 exhibited 10 behavior episodes.</p> <p>A Behavior/Medication Monitoring Summary, dated February 2016, indicated Resident #4 exhibited 44 verbal assaults to staff, 12 verbal assaults to peers, 64 social inappropriate episodes, and was resistive to cares/noncompliant 5 times. On 2/20/16 staff documented Resident #4 self-transferred as a behavior. On 2/23/16 staff documented Resident #4 was very confused on the night shift while aides were re-stocking her supplies and asked them not to take anything out of her closet. According to the behavior monitoring log Resident #4 exhibited 32 episodes of behavior on 2/21/16, 43 episodes of behavior on 2/27/16, and 17 episodes of behavior on 2/28/16. There was no documentation regarding the specifics of the behaviors for those days.</p> <p>A Nurses' Note, dated 2/21/16, noted Resident #4 exhibited 3 behaviors including verbal assault to 2 male residents and verbal assault to a visitor with small children, asking them to be quiet. This day staff documented 32 behavioral episodes.</p> <p>A Nurses' Note, dated 2/27/16, documented no behaviors were noted on morning or evening shifts. This day staff documented 43 episodes of behavior.</p> <p>There was no nurse' note from the day or evening shift dated 2/28/16. Staff documented</p>	F 514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/21/2016</b>
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F 514	Continued From page 31 Resident #4 had 17 episodes of behavior on that day.  During an interview on 10/20/16 at 10:10 am, the DON said the numbers on the behavior monitoring sheets indicated the number of occurrences of a particular behavior. She said she would not consider Resident #4 complaining about food and not receiving soda as a behavior. She said she expected the nursing staff to be more descriptive of Resident #4's behaviors on the behavior monitoring tool and in the nurses' notes. The DON said she expected the CNAs to communicate with nurses regarding any resident's behaviors. The DON said the facility staff based their decisions regarding a resident's care and medications partly on those behavior monitoring sheets so it was important that they were accurate.	F 514			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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RICHARD M. ARMSTRONG – Director

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January 6, 2017

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

Provider #: 135089

Dear Ms. Riedel:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Desert View Care Center of Buhl. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey October 17, 2016 through October 21, 2016.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007264**

**ALLEGATION #1:**

The Reporting Party said an identified resident was not provided access to his/her call light and had to toilet him/herself due to the call light not being accessible.

**FINDINGS:**

Call light accessibility and response times were observed throughout the survey. Residents' oxygen was observed. Nursing staff were observed as they passed medications to facility residents. The facility was observed for overall cleanliness, including lingering odors, throughout the survey. Shelves in residents' rooms were observed for safety.

Cynthia Riedel, Administrator  
January 6, 2017  
Page 2 of 4

The clinical record of the identified resident was reviewed and 10 other residents' records were reviewed for Quality of Care concerns. The facility's 2016 Grievance file was reviewed. Resident Council minutes from July to September 2016 were reviewed. The facility's Incident and Accidents reports from March to October 2016 were reviewed.

Several residents, CNAs, nurses, and a housekeeper were interviewed regarding Quality of Care and Quality of Life concerns. The Maintenance Supervisor, the Director of Nurses and the Administrator were interviewed regarding various issues.

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Call lights were observed throughout the survey and no concerns were identified.

The identified resident's record was reviewed and no concerns were identified. Resident Council minutes were reviewed and no concerns regarding call lights were identified.

Five individual residents and several residents in the Group meeting said there were no concerns regarding call lights. Several CNAs and Nurses said they made sure residents had their call lights accessible to them.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

An identified resident did not receive his/her medications as ordered.

#### FINDINGS #2:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F309.

#### CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

An identified resident's oxygen tank was empty and the resident did not receive enough oxygen to maintain appropriate saturation levels.

FINDINGS #3:

Based on record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F328.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility was not clean and had lingering odors.

FINDINGS:

The facility was observed for overall cleanliness, including lingering odors, throughout the survey and no concerns were identified.

The facility's 2016 Grievance file and the Resident Council minutes from July to September 2016 were reviewed and no concerns regarding cleanliness or lingering smells were identified.

Several individual residents and residents in the Group Interview said there were no concerns regarding cleanliness or lingering smells. A Housekeeper said rooms and common areas were cleaned daily and if a smell was identified, she would find the cause and find a solution to the problem area.

Based on observation, record review, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

A shelf above an identified resident's bed was unsafe.

Cynthia Riedel, Administrator  
January 6, 2017  
Page 4 of 4

**FINDINGS:**

Shelves in all residents' rooms were observed for safety and no concerns were identified.

The facility's 2016 Grievance file and the facility's Incident and Accidents reports from March to October 2016 were reviewed and there were no incidents identified regarding unsafe shelving.

Several residents said they had no concerns regarding shelf safety. The Maintenance Supervisor said all the shelves in resident rooms were safe and were secured into wall studs.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

Thank you for the courtesies and assistance extended to us during our visit.

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,

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

Nina Sanderson, L.S.W., Supervisor  
Long Term Care

NS/lj



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HEALTH & WELFARE

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March 17, 2017

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

Provider #: 135089

Dear Ms. Riedel:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Desert View Care Center of Buhl. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted October 17, 2016 through October 21, 2016.

The identified resident was observed for proper medication administration and fall precautions. Two other residents were observed for Quality of Care concerns. Medication pass was observed.

The identified resident's clinical record and 11 other residents' records were reviewed for Quality of Care concerns. The facility's Incident and Accident reports from March to October 2016 were reviewed.

The identified resident and three other residents were interviewed regarding Quality of Care concerns. Several staff were interviewed. The Director of Nursing, Resident Care Manager and Administrator was interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007252**

ALLEGATION #1:

The Reporting Party said an identified resident was given an inappropriate gradual dose reduction for a medication.

FINDINGS:

Based on observation, record review, resident and staff interview, it was determined the allegation was substantiated and the facility was cited at F329 and F514.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident fell in the facility due to lack of supervision and a recent medication change.

FINDINGS:

The identified resident's clinical record and a fall investigation report documented that fall precautions were appropriate and in place prior to- and after the resident fell in the facility. However, based on record review and staff interview, it was determined the allegation was substantiated for another resident and the facility was cited at F323.

ALLEGATION #3:

An identified resident's Interested Party was not informed of a change of condition.

FINDINGS:

The identified resident's clinical record and six other residents' records did not indicate a concern regarding proper notification following a change of condition.

A resident's family member did not voice a concern regarding notification by the facility when there was a change in condition. The Administrator said the appropriate family members were always notified of changes of condition.

Based on record review, family and staff interview, it was determined the allegation could not be substantiated.

Cynthia Riedel, Administrator  
March 17, 2017  
Page 3 of 3

CONCLUSIONS:

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,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a smaller "Scott" following it.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj



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March 17, 2017

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

Provider #: 135089

Dear Ms. Riedel:

On **October 21, 2016**, an unannounced on-site complaint survey was conducted at Desert View Care Center of Buhl. The allegation was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted October 17, 2016 through October 21, 2016.

Six residents were observed for pressure ulcer precautions.

The clinical record of the identified resident and six other residents' records were reviewed for Quality of Care concerns. The facility's Incident and Accident reports from March 2016 to October 2016 were reviewed.

Residents and a family member were interviewed for Quality of Care concerns. Several Certified Nurses Aides (CNA) and Nurses, including the wound care nurse, were interviewed regarding Quality of Care concerns. The Director of Nursing was interviewed regarding pressure ulcer care and prevention. The Administrator was interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007360**

ALLEGATION #1:

The Reporting Party said an identified resident was admitted with a wound and the facility did not provide appropriate pressure ulcer precautions, including equipment and repositioning.

FINDINGS:

The identified resident was no longer residing in the facility at the time the complaint was investigated.

The clinical record of the identified resident documented the resident received appropriate repositioning and wound treatment. Six other residents' records were reviewed for pressure ulcer precautions and proper equipment and no concerns were identified for correct wound healing and repositioning.

Several CNAs and Nurses said residents received appropriate pressure ulcer precautions. The Wound Nurse and the Director of Nursing said the resident received appropriate care planning, pressure ulcer precautions, and equipment when necessary and interventions were put into place by the Speech Therapist and Dietician to improve the resident's appetite.

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An Interested Party was not notified of changes to an identified resident's change of condition.

FINDINGS:

The identified resident's clinical record indicated the interested party was not the Power of Attorney and the facility contacted the Power of Attorney when there was a change in condition of the resident. Six other residents' records did not indicate a concern regarding proper notification following a change of condition.

The Administrator said the Power of Attorney and/or the appropriate family members were always notified of changes of condition.

Cynthia Riedel, Administrator  
March 17, 2017  
Page 3 of 3

Based on record review and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

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 black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj