



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

October 18, 2019

Amund Evans, Administrator  
Desert View Care Center of Buhl  
820 Sprague Avenue  
Buhl, ID 83316-1827

Provider #: 135089

Dear Mr. Evans:

On **October 3, 2019**, 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **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.

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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 **October 28, 2019**. Failure to submit an acceptable PoC by **October 28, 2019**, may result in the imposition of penalties by **November 20, 2019**.

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 7, 2019 (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 3, 2020**. A change in the seriousness of the deficiencies on **November 17, 2019**, 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 3, 2020** includes the following:

Denial of payment for new admissions effective **January 3, 2020**. [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 3, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, 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 3, 2020** 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:

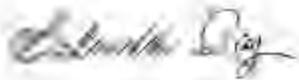
- BFS Letters (06/30/11)

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

This request must be received by **October 28, 2019**. If your request for informal dispute resolution is received after **October 28, 2019**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

bd/lj

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

PRINTED: 11/01/2019  
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>10/03/2019</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	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint investigation survey conducted from September 30, 2019 through October 3, 2019.  The surveyors conducting the survey were:  Cecilia Stockdill, RN, Team Coordinator Jennifer Walker, RN Michael Brunson, RN  Abbreviations:  DNR = Do Not Resuscitate DON = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set mg = milligram POST = Physician's order for Scope of Treatment RN = Registered Nurse RSC = Resident Services Coordinator	F 000			
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		11/5/19	

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

TITLE

(X6) DATE

Electronically Signed

10/25/2019

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 578	<p>Continued From page 1 subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure: a) residents were given the facility's policy and Idaho state statutes regarding Advance Directives upon admission, and thereafter, and were assisted to formulate an Advance Directive if so desired, b) residents' records included documentation of this process, a copy of the Advance Directive, or documentation the resident did not wish to</p>	F 578	<p>Residents #2, #10, and #24 received the resident handbook and policy regarding the advance directives and Living Wills on 10/24/19. The living will template was given to the resident or their responsible party.</p> <p>All residents with no advance directives was given a copy of the resident handbook and policy regarding advance</p>		

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F 578	<p>Continued From page 2</p> <p>formulate an Advance Directive, and c) residents' living wills identified their healthcare choices should they become incapacitated, or their records documented the reason for not identifying choices. This was true for 4 of 12 residents (#2, #10, #17, and #24) reviewed for Advance Directives. These failures created the potential for harm should residents not have their decisions documented, honored, and respected when they were unable to make or communicate their health care preferences. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an Advanced Directive as "...a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The State Operations Manual also states a Physician Orders for Life-Sustaining Treatment (POLST) is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an Advance Directive.</p> <p>The facility's Advance Directives policy, dated October 2017, documented the following:</p> <p>* Upon admission written information was provided to residents of their right under State Law to accept or refuse medical treatment, formulate Advanced Directives, Durable Power of</p>	F 578	<p>directives and living wills and the living will template.</p> <p>A checklist has been developed for new admissions and to review with each MDS update to ensure the residents have advance directives in place or have been offered the opportunity to complete them. The staff will be in-serviced on the right of the resident and/or representative to formulate an advance directive. As well as in-serviced on the Living Will, this includes choices for emergency and end of life care.</p> <p>All new admission charts will be audited by Medical Records or a designee to ensure the advance directive information has been provided and documented in the record weekly X4, Bi-Monthly X2, Monthly X3, and Quarterly there after. The results of the will be shared with QAPI committee to determine if audits continue to indicate issues.</p>		

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F 578	<p>Continued From page 3 Attorney (DPOA), or living will. * At time of admission, residents were provided written information on advanced directives and this was documented in residents' medical records. * Education was provided to the staff and community about advanced directives.</p> <p>This policy was not followed.</p> <p>1. Resident #17 was admitted to the facility on 2/8/19, with multiple diagnoses including major depressive disorder and heart failure. A quarterly MDS assessment, dated 8/13/19, documented Resident #17's cognition was severely impaired.</p> <p>Resident #17's record documented a Power of Attorney for financial services and a POST for DNR code status. Resident #17's record did not include documentation of an Advanced Directive or that Advanced Directives were discussed with him and his representative.</p> <p>A Care Conference Plan, dated 6/13/19, did not include documentation the facility reviewed Advance Directive information with Resident #17 and his representative.</p> <p>On 9/30/19 at 4:10 PM, the RSC stated she had been reviewing and discussing residents' code status with them and was not reviewing Advanced Directives with them. She acknowledged Resident #17's record did not include Advance Directives or documentation they were discussed with him and his representative.</p> <p>2. Resident #10 was admitted to the facility on</p>	F 578			

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F 578	<p>Continued From page 4</p> <p>3/1/19, with multiple diagnoses including hypertension and bipolar disorder.</p> <p>A quarterly MDS assessment, dated 5/21/19, documented Resident #10 was cognitively intact.</p> <p>Resident #10's Living Will and Durable Power of Attorney for Healthcare form, signed by him on 5/17/19, designated a DPOA. The living will section of the form, which included choices for end of life and emergency care, related to the use of artificial life sustaining equipment, the use of non-artificial and artificial hydration and nutrition, and pain management, was left blank and did not identify his wishes.</p> <p>On 9/30/19 at 4:04 PM, the RSC stated Resident #10 wanted to review his living will with his appointed DPOA prior to checking the boxes for his wishes.</p> <p>A Care Conference Plan, dated 7/10/19, did not include documentation the facility reviewed the Living Will and Durable Power of Attorney for Healthcare form with Resident #10 and his representative.</p> <p>On 10/1/19 at 3:00 PM, the RSC stated she had reviewed Resident #10's resuscitation code status, not his Advance Directive, during the care plan conference.</p> <p>3. Resident #2 was admitted to the facility on 8/27/18, with multiple diagnoses including dementia and Parkinson's disease (a progressive nervous system disorder that affects movement).</p> <p>Resident #2's record did not include</p>	F 578			

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F 578	<p>Continued From page 5</p> <p>documentation the facility's policy and Idaho state statutes for Advance Directives was provided to, or discussed with him and his representative.</p> <p>On 10/2/19 at 3:15 PM, the RSC stated she reviewed the resuscitation code status with Resident #2's representative, not Advance Directives.</p> <p>4. Resident #24 was readmitted to the facility on 6/6/17, with multiple diagnoses including cardiomyopathy (a disease of the heart muscle that makes it harder to pump blood to the rest of the body) and atrial fibrillation (irregular heart rhythm).</p> <p>Resident #24's significant change MDS assessment, dated 8/30/19, documented he was cognitively intact.</p> <p>A Care Conference Meeting Note, dated 9/16/19 at 10:56 AM, documented Resident #24's POST form was reviewed, and DPOA papers were discussed and completed per his choice.</p> <p>Resident #24's Living Will and DPOA form, dated 9/18/19, documented he designated a DPOA. The living will section of the form, which included choices for emergency and end of life care, related to the use of artificial life sustaining equipment, the use of non-artificial and artificial hydration and nutrition, and pain management, was left blank and did not identify his wishes. Resident #24's record did not include documentation of the reason the living will was not completed.</p>	F 578			

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F 578	Continued From page 6 On 10/3/19 at 9:26 AM, the RSC acknowledged Resident #24's living will did not document his wishes. The RSC said Resident #24 did not want to sign a living will, but there was no documentation he declined the opportunity to complete it.	F 578			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)  §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.  §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		11/5/19	

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F 582	<p>Continued From page 7</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC), and staff interview, it was determined the facility failed to ensure residents received appropriate notification prior to the last day of Medicare covered services. This was true for 2 of 3 residents (#3 and #138) reviewed for Beneficiary Protection Notification. This failure created the potential for harm if residents were not aware of their potential responsibility to pay for services and their right to appeal the decision of Medicare to end payment for services. Findings include:</p> <p>The instructions for the Notice of Medicare</p>	F 582	<p>Resident #3 NOMNC was never signed by resident or representative on 4/3/19 prior to their Medicare coverage ending. The Skilled Nursing Advance Beneficiary Notice of Non-Coverage (SNFABN) should have been signed 4/6/19 by was delayed until 4/8/19 for Resident #3. Resident #138 was discharged from Desert View Care Center on 8/6/19.</p> <p>All residents on Medicare had the potential to be affected.</p> <p>Therapy, resident services and nursing staff will be in-serviced on the</p>		

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F 582	<p>Continued From page 8</p> <p>Non-Coverage CMS-10095 (NOMNC), undated, documented a Medicare health provider must give an advance, completed copy of the NOMNC to enrollees receiving skilled nursing services no later than two days before services were terminated.</p> <p>1. Resident #3 was readmitted to the facility on 3/25/19, with multiple diagnoses including anoxic brain damage (brain damage due to lack of oxygen) and sepsis (an overwhelming and life-threatening response to infection).</p> <p>Resident #3's NOMNC documented his Medicare-covered skilled nursing services ended on 4/5/19. The signature line for the resident/representative and the date of the signature were blank. A handwritten note documented "Verbally informed of the non coverage of services via telephone on 4/3/19," and it was signed by the RSC. There was no documentation of who received the notice or that a copy of the form was mailed or provided to the resident and/or his representative.</p> <p>Resident #3's Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) documented his skilled nursing and therapy services did not meet Medicare coverage requirements, and he may be responsible for the costs starting on 4/6/19. The document was signed by Resident #3's representative on 4/8/19, which was two days after his Medicare coverage was to end.</p> <p>On 10/2/19 at 9:08 AM, the RSC said she was not sure why Resident #3's NOMNC was not signed, and she usually sent a copy to his</p>	F 582	<p>requirements for issuing a NOMNC or SNFABN.</p> <p>All Medicare residents' charts will be audited by the MDS coordinator or designee to ensure NOMNC or SNFABN was offered and documented weekly X4, Bi-Monthly X2, Monthly X3 and Quarterly there after. Results of the audits will be shared with QAPI committee to determine if audits continue to indicate issues.</p>		

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F 582	Continued From page 9 representative by email or regular mail.  The facility did not provide documentation a NOMNC or SNFABN were provided to Resident #3 and/or his representative prior to his Medicare coverage ending.  2. Resident #138 was admitted to the facility on 7/11/19, with multiple diagnoses including dementia, hypertension (high blood pressure), and a fracture of the left femur (thigh bone).  Resident #138's NOMNC documented her Medicare coverage for skilled nursing and therapy services ended on 8/6/19. The NOMNC was signed by Resident #138 on 8/6/19, the same day her Medicare coverage was to end.  On 10/2/19 at 9:13 AM, the RSC said she was trained to have residents sign the NOMNC on their day of discharge.  On 10/2/19 at 9:56 AM, RN #1 said the facility followed the form instructions for the NOMNC. RN #1 said staff should obtain the resident's signature on the NOMNC prior to discharge so the resident had time to file an appeal if they desired.	F 582			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		11/5/19	

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F 657	<p>Continued From page 10</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and resident and staff interview, it was determined the facility failed to ensure residents' care plan conferences were held following each annual and quarterly assessment. This was true for 1 of 12 residents (Resident #12) whose care plans were reviewed. This failure created the potential for harm if residents and/or their representative were not included in making decisions regarding residents' care. Findings include:</p> <p>Resident #12 was admitted to the facility on 7/16/18, with multiple diagnoses including dementia without behavioral disturbance, mood disorder, and chronic pain.</p>	F 657	<p>Resident #12, no documented care plan conference was found. Resident #12 had a care conference on 10/22/19.</p> <p>All residents have the potential to be affected. Any resident found without a timely care conference will have a care conference scheduled with the resident and their representatives if applicable.</p> <p>Care conferences are now scheduled in conjunction with each MDS review. Care conferences will be scheduled with each resident and their representative if applicable. Scheduling of the care conferences with the residents and family</p>		

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F 657	Continued From page 11 Resident #12's annual MDS assessment, dated 7/23/19, documented she was cognitively intact.  An Interdisciplinary Plan of Care Conference, dated 2/21/19, documented a quarterly care conference was held with Resident #12 in attendance. No documented care plan conferences were found in Resident #12's record after 2/21/19.  On 9/30/19 at 2:01 PM, Resident #12 said she had not recently attended a care plan meeting.  On 10/2/19 at 3:08 PM, the RSC said the facility had an issue and scheduling care conferences got off track. The RSC said some care conferences got dropped, and Resident #12's was one of them. The RSC said if she did not find any other documentation of care conferences, then Resident #12's last care conference was on 2/21/19.  The facility did not provide documentation of care conferences after 2/21/19 for Resident #12.	F 657	representative will be the responsibility of the Resident Services Director. Staff will be in-serviced on the requirements for care plan timing and revision.  The care conference calendar and care conference notes will be audited by the MDS coordinator or designee to ensure each resident has had a care conference in a timely manner weekly X4, Bi-Monthly X2, Monthly X3, and Quarterly there after. Results will be shared with QAPI committee to determine if audits continue to indicate issues.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		11/5/19	

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F 684	<p>Continued From page 12</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure physician orders were followed. This was true for 1 of 12 residents (Resident #24) reviewed for quality of care. This created the potential for harm if residents did not receive care and services as ordered by the physician. Findings include:</p> <p>Resident #24 was readmitted to the facility on 6/6/17, with multiple diagnoses including Type 2 diabetes mellitus and history of diseases of the skin and subcutaneous tissue (the innermost layer of skin, made up of fat and connective tissues).</p> <p>Resident #24's Significant Change MDS assessment, dated 8/30/19, documented he was cognitively intact, he had one venous/arterial ulcer (an open sore that results from damage to arteries or veins), and a diabetic foot ulcer.</p> <p>Resident #24's record included a physician order, dated 8/15/19, to obtain an x-ray of the left foot wound and get a wound care consult. The order was noted and signed by a nurse on 8/15/19.</p> <p>On 10/1/19 at 9:32 AM, LPN #1 was observed performing a dressing change and wound care to Resident #24's left heel and lower leg. LPN #1 said Resident #24 had a diabetic ulcer and an arterial ulcer. A large, shallow wound was observed on Resident #24's left heel, and a smaller shallow wound was observed on his left lower leg.</p> <p>On 10/3/19 at 9:58 AM, the DON said she was not sure if the wound care consult occurred for</p>	F 684	<p>Resident #24 was found to have missed a wound consult appointment on 8/15/19. Resident #24 has a wound consult appointment scheduled for 10/25/19.</p> <p>All residents have a potential to be affected. Physician orders will be reviewed by nursing administration five days a week. Nursing staff will be in-serviced regarding noting and processing physician orders.</p> <p>A physician order checklist has been created and a copy will be given to nursing administration for review.</p> <p>The DNS or designee will audit physician orders to ensure they have been followed and documented on weekly X4, Bi-Monthly X2, Monthly X3, and Quarterly there after. Audit results will be shared with QAPI committee to determine if audits continue to indicate issues.</p>		

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F 684	Continued From page 13 Resident #24's left foot. On 10/3/19 at 11:42 AM, the DON said the referral to the wound clinic was lost so it did not happen.	F 684			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure respiratory care and treatments were delivered according to facility policy and physician's order. This was true for 2 of 2 residents (#13 and #24) reviewed for respiratory care. This created the potential for harm from respiratory infections due to growth of pathogens (organisms that cause illness) in respiratory treatment equipment. Findings include:  The facility's policy for Oxygen Use, adopted October 2017, documented the following:  * If a disposable humidifier was used, it could be used until empty. * If a reusable humidifier was used, it should be emptied, rinsed, dried, and refilled with sterile water daily. It should be labeled with the date, time, and initials.	F 695	Residents #13 and #24 had their respiratory equipment changed 10/3/19 and 10/15/19 with the next scheduled time being 11/1/19. Resident #24 had his nebulizer changed 10/3/19 and 10/15/19.  All residents with respiratory/tracheostomy care have the potential to be affected. All residents with respiratory/tracheostomy care equipment were checked and all equipment has been changed per the policy.  A check off list has been created for staff to use when changing oxygen tubing, mister machine tubing, filters, humidifiers and nebulizer cleaning and storage. The nursing staff will be given a copy of the policy and in-serviced on the requirements of Respiratory/Tracheostomy Care and	11/5/19	

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F 695	<p>Continued From page 14</p> <p>* Reusable humidifiers should not be stored with water in them because microorganisms may grow in the water.</p> <p>The facility's policy for Nebulizer Tubing and/or Mask, adopted October 2017, documented the nebulizer tubing and/or mask should be cleaned regularly.</p> <p>The facility's policies were not followed.</p> <p>1. Resident #13 was readmitted to the facility on 5/5/15, with multiple diagnoses including persistent vegetative state, injury to the cervical spine, diseases of the upper respiratory tract, quadriplegia (paralysis of all 4 extremities), and tracheostomy (an artificial opening into the airway to allow breathing).</p> <p>Resident #13's quarterly MDS assessment, dated 7/30/19, documented he received oxygen therapy.</p> <p>Resident #13's physician orders documented the following:</p> <p>* Change the oxygen filter/humidifier, oxygen tubing, and suction canisters/lids/tubing on the 1st and 15th of the month, dated 8/1/17.</p> <p>* A mister machine (a machine that provides humidity) to be set between 30-40, with oxygen at 2 liters via the tracheostomy every night, dated 2/6/19.</p> <p>Resident #13's care plan directed staff to change the oxygen tubing, mister machine tubing, filter, humidifier and suction canisters/lids/tubing on the 1st and 15th of every month and as needed. The</p>	F 695	<p>Suctioning. This will include but not limited to changing oxygen tubing, mister machine tubing, filters, humidifiers and nebulizer cleaning and storage.</p> <p>Audits of all residents with respiratory/tracheostomy care including documentation of equipment changes on the treatment administration record will be completed by the DNS or designee weekly X4, Bi-Monthly X2, Monthly X3, and Quarterly there after. The results will be shared with QAPI committee to determine if audits continue to indicate issues.</p>		

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F 695	<p>Continued From page 15 intervention was initiated on 7/30/19 and revised on 7/31/19.</p> <p>On 10/1/19 at 10:15 AM, Resident #13 was lying in bed. He had a tracheostomy in place that was draining a large amount of yellow/white secretions. Respiratory equipment, including a mister machine, was present at his bedside but was not connected to his tracheostomy. The humidifier bottle was dated 8/31/19.</p> <p>On 10/2/19 at 8:36 AM, Resident #13 was lying in bed with humidified oxygen connected to his tracheostomy. The humidifier bottle was dated 8/31/19. RN #2 said the humidifier bottle should be changed on the 1st and 15th of the month. RN #2 said Resident #13's humidifier bottle was supposed to be changed the night before, and she heard a staff member say she could not find any more humidifier bottles so she rinsed out the existing humidifier bottle and refilled it.</p> <p>On 10/2/19 at 10:40 AM, the DON said the humidifier water bottle should be changed on the 1st and 15th of the month, and as needed.</p> <p>2. Resident #24 was readmitted to the facility on 6/6/17, with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>Resident #24's physician orders, dated 4/25/19, documented Duoneb Solution (medication to help open the airways) 0.5-2.5 mg /3 ml (milliliters) inhale via nebulizer (a machine that turns liquid medicine into a mist) twice a day for cough.</p>	F 695			

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F 695	Continued From page 16 Resident #24's September 2019 and October 2019 Medication Administration Records documented the Duoneb was administered each day from 9/1/19 through 10/3/19.  On 10/1/19 at 9:45 AM, a nebulizer administration set, dated 9/19/19, was on Resident #24's dresser. The nebulizer administration set was attached to a nebulizer machine, and it was not in a bag.  On 10/3/19 at 9:40 AM, a nebulizer administration set, dated 9/19/19, was on Resident #24's dresser. The nebulizer administration set was attached to a nebulizer machine, and it was not in a bag. Resident #24 said he used the nebulizer approximately 5 days a week.  On 10/3/19 at 10:01 AM, the DON said when a nebulizer administration set was not in use it should be stored in a bag to prevent contamination, and it should be changed on the 1st and the 15th of the month. The DON said usually it was scheduled on the Treatment Administration Record for the night shift staff to change the nebulizer administration set.	F 695			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		11/5/19	

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F 758	<p>Continued From page 17</p> <p>(iii) Anti-anxiety; and</p> <p>(iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p>	F 758			

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F 758	<p>Continued From page 18</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 gradual dose reductions (GDRs) were attempted for psychotropic medications. This was true for 1 of 5 residents (Resident #12) reviewed for unnecessary medications. This failure created the potential for harm if residents received psychotropic medications that were unnecessary, ineffective, or used for excessive duration, and placed residents at risk for adverse reactions from psychotropic medications. Findings include:</p> <p>Resident #12 was admitted to the facility on 7/6/18, with multiple diagnoses including obsessive-compulsive disorder, depression, and anxiety.</p> <p>Resident #12's annual MDS assessment, dated 7/23/19, documented she was cognitively intact, and she received antipsychotic, antianxiety, and antidepressant medication on 7 of the 7 previous days.</p> <p>Resident #12's physician orders documented the following:</p> <ul style="list-style-type: none"> <li>* Lorazepam (antianxiety medication) 0.5 mg one tablet once a day for anxiety, starting on 7/17/18.</li> <li>* Lorazepam 0.5 mg two tablets at bedtime for anxiety, starting on 7/16/18.</li> <li>* Quetiapine (antipsychotic medication) 200 mg one tablet at bedtime for mood stabilizer, starting on 7/16/18.</li> <li>* Sertraline (antidepressant) 100 mg 2 tablets once a day for depression, starting on 8/29/18.</li> </ul>	F 758	<p>Resident #12's physician was contacted on 10/24/19 requesting documentation regarding the continued need of the psychotropic medication at the current dose or to provide an order for a dose reduction.</p> <p>All residents with orders for psychotropic medications could be affected. Residents will be reviewed quarterly in psychotropic drug review. Any found to be out of compliance their physician will be contacted regarding the continue need of psychotropic medication at the current dose or to provide an order for a dose reduction. All residents are reviewed quarterly in psychotropic drug review. The psychotropic drug review staff will be in-serviced on the requirements for gradual dose reduction and the residents right to be free of unnecessary psychotropic medications.</p> <p>All psychotropic orders will be audited by the DNS or designee to ensure compliance weekly X4, Bi-Monthly X2, Monthly X3, and Quarterly there after. Results will be shared with QAPI committee and reviewed to determine if they continue to indicate issues.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 19 Resident #12's record did not include documentation a GDR was attempted or contraindicated since 8/22/18.  On 10/2/19 at 2:12 PM, the DON said there were no GDRs attempted for Resident #12's psychotropic medications. The DON said Resident #12 saw a psychiatrist whom she preferred, and there was no documentation found regarding GDRs.	F 758			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of	F 849		11/5/19	

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F 849	Continued From page 20 the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of	F 849			

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F 849	<p>Continued From page 21</p> <p>the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State</p>	F 849			

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F 849	Continued From page 22 scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides	F 849			

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F 849	<p>Continued From page 23</p> <p>orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, contract review, and staff interview, it was determined the facility failed to ensure planned hospice services included delineation of duties between the facility and the hospice agency. This was true for 1 of 1 resident (Resident #19) reviewed for hospice care. This failure created the potential for harm if residents received inadequate care related to hospice services. Findings include:</p> <p>The facility's policy for Hospice Program, undated, documented the following:</p> <ul style="list-style-type: none"> <li>* When a resident participated in a hospice program, a coordinated plan of care was developed between the facility, hospice agency, and resident/family.</li> <li>* All hospice services were provided under contractual arrangements, and complete details regarding the responsibilities of the facility and the hospice agency were in the contractual agreement.</li> </ul>	F 849	<p>Resident #19 care conference on 10/23/19 with the facility and hospice service. The facility received delineation of duties and hospice descriptions and roles during visits were documented in resident #19 care plan.</p> <p>All residents with hospice agency have the potential to be affected. Upon a resident's admission to hospice the facility will receive delineation of duties and hospice descriptions and roles during visits and will be documented in the care plan.</p> <p>Delineation of duties will be discussed on new admits to hospice in the future. Current residents will be reviewed in care conferences. All staff will be in-serviced on the responsibilities or delineation of duties between the hospice agency and the facility.</p>		

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F 849	Continued From page 24 This policy was not followed.  Resident #19 was admitted to the facility on 8/4/15, with diagnoses which included heart disease and dementia.  A physician order, dated 10/11/18, documented an order for Resident #19 to be evaluated for hospice care. Resident #19 was admitted to a hospice agency for services on 10/17/18, with diagnoses of senile degeneration of the brain.  Resident #19's care plan documented she was on hospice care. The care plan did not include documentation of the responsibilities or care delineated between the facility and the hospice agency.  The contract between the facility and the hospice agency did not document the details of responsibilities delineated between the facility and the hospice agency.  On 10/1/19 at 3:40 PM, RN #1 said he did not find documentation regarding delineation of duties between the facility and the hospice agency, and it should have been documented in the hospice plan of care for Resident #19.	F 849	Audits of new hospice admissions to ensure information has been provided and documented will be performed by the MDS coordinator or designee weekly X4, Bi-Monthly X2, Monthly X3, and Quarterly there after. Results of the audits will be reviewed by the QAPI committee to determine if they continue to indicate issues.		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		11/5/19	

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F 880	Continued From page 25  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880			

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F 880	<p>Continued From page 26</p> <p>(v) The circumstances under which 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; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff handled, processed, and transported laundry in a sanitary manner. This was true for 12 of 12 residents (#2, #9, #10, #12, #13, #17, #19, #24, #26, #33, #35, and #36) reviewed for infection control and had the potential to impact the other 25 residents residing in the facility. These failures created the potential for the residents to develop infection from cross-contamination of linens. Findings include:</p> <p>The facility's Departmental (Environmental Services) - Laundry policy, dated September 2014, documented staff sorting or washing laundry must wear a gown and gloves. A mask</p>	F 880	<p>All residents #2, #9, #10, #12, #13, #17, #19, #24, #26, #33, #35 and #36 were affected. Staff was given the policy and in-serviced regarding the proper handling of soiled lines on 10/15/19.</p> <p>All residents have the potential to be affected. Staff was given the policy an in-serviced regarding the proper handling of soiled lines on 10/15/19.</p> <p>A checklist and instruction sheet with pictures was created and for the staff to reference at any time.</p> <p>Audits will be performed by the</p>		

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F 880	<p>Continued From page 27 may be worn when aerosolization can occur.</p> <p>This policy was not followed.</p> <p>On 10/03/2019 at 4:15 PM, Laundry Staff #1 stated the facility had a washer and dryer. Laundry Staff #1 described the laundering process of accepting, separating, cleaning, drying, folding, and returning residents clothing. Laundry Staff #1 stated they applied gloves, sorted the clothing, separated darks and colors and linens, and then transported the dirty laundry to the washer. Laundry Staff #1 stated once the dirty laundry was placed in the washer, she removed her gloves and washed her hands. After the wash cycle was completed, she applied clean gloves, then transferred the clean laundry from the washer to the dryer. After the dryer cycle was completed, Laundry Staff #1 stated the laundry was transferred from the dryer to the folding area, where it was folded, placed on a rack, covered, and then delivered to the residents' rooms. Laundry Staff #1 stated she wore gloves with no other protective equipment during the laundry process.</p> <p>On 10/3/19 at 4:29 PM, the DON stated she understood by not wearing a gown or gloves while transferring the dirty laundry, the staff were at risk of cross contaminating residents' personal laundry.</p> <p>On 10/3/19 at 4:38 PM, the Maintenance Supervisor stated the staff should have been wearing a gown, gloves, and goggles when handling dirty laundry.</p>	F 880	<p>housekeeping supervisor or designee on the proper use of personal protective equipment weekly X4, Bi-Monthly X2, Monthly X3 and Quarterly there after. Audit results will reviewed by the QAPI committee to determine if they continue to indicate issues.</p>		



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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January 21, 2020

Amund Evans, Administrator  
Desert View Care Center of Buhl  
820 Sprague Avenue  
Buhl, ID 83316-1827

Provider #: 135089

Dear Mr. Evans:

On **September 2019** through **October 3, 2019**, an unannounced on-site complaint survey was conducted at Desert View Care Center of Buhl. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007887**

**ALLEGATION #1:**

The facility failed to communicate with residents' family members/representatives regarding the residents' conditions.

**FINDINGS #1:**

The records of 4 residents were reviewed regarding transfers to the hospital. Four of 4 resident records documented the family/representative was notified of the residents' transfer to the hospital.

Grievances and Incidents and Accidents were reviewed for the previous six months. There were no documented grievances regarding residents' family/representative not being notified of their condition.

Eight residents were interviewed individually and a resident council interview was held with 8 residents in attendance. Eight of 8 residents had no concerns regarding their family/representative being notified of their condition. During the resident council interview, residents stated their family/representative were notified when they were transferred to the hospital and they had no concerns regarding their family/representative being notified of their condition.

It could not be determined that the facility failed to communicate with residents' family members/representatives regarding the residents' conditions. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

### **CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

### **ALLEGATION #2:**

The facility failed to ensure residents were free from abuse.

### **FINDINGS #2:**

Staff were observed interacting with residents throughout the survey. Staff members were observed interacting appropriately with residents at all times throughout the survey.

Five staff members, including nursing staff, activities staff, and social services staff, were interviewed. All 5 staff members identified different types of abuse and verbalized appropriate responses if they witnessed abuse.

The records of 9 residents were reviewed. None of the 9 resident records documented evidence of abuse.

Grievances and Incidents and Accidents were reviewed for the previous six months. One grievance documented a staff member being rude to a resident. The facility responded appropriately to the grievance and there were no further grievances regarding staff being rude or resident abuse.

Eight residents were interviewed individually and a resident council interview was held with 8 residents in attendance. Eight of 8 residents had no concerns about abuse. During an interview with the resident council, there were no concerns expressed regarding abuse.

It could not be determined that the facility failed to ensure residents were free from abuse. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The facility failed to ensure residents were free from neglect.

**FINDINGS#3:**

Staff were observed interacting with residents, and the condition of residents was observed throughout the survey. Residents appeared appropriately groomed and care for, and staff were observed responding to residents' needs in an appropriate manner throughout the survey.

The records of 9 residents were reviewed. All 9 resident records documented care was provided appropriately and as ordered/care planned.

Eight residents were interviewed individually and a resident council interview was held with 8 residents in attendance. Eight of 8 residents verbalized no concerns regarding neglect. During an interview with the resident council, there were no concerns expressed regarding neglect.

It could not be determined that the facility failed to ensure residents were free from neglect. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The facility failed to ensure the wishes of residents/family were honored regarding transferring to a different facility.

**FINDINGS #4:**

Grievances were reviewed for the prior six months. There were no documented grievances addressing a resident/family's wishes not being honored regarding transferring to a different facility.

The records of 4 residents were reviewed regarding transfers to the hospital. Four of 4 resident records documented the family/representative was notified of the residents' transfer to the hospital.

One resident record documented she was her own decision maker prior to being transferred to the hospital. The resident was admitted to the hospital, and subsequently went from the hospital to a different facility per the family's request. There was no documentation of the resident wishing to be transferred to a different facility.

Three staff members were interviewed. All 3 staff members stated there would not be any circumstance where the facility would not facilitate a resident transferring to a different facility if that was the resident's wish, and they were not aware of that ever occurring. Two staff members said they were aware of 1 resident requesting to transfer to a different facility, and the transfer was accomplished.

It could not be determined that the facility failed to ensure the wishes of residents/family were honored regarding transferring to a different facility. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The facility failed to ensure residents who were not able to speak for themselves had an advocate.

**FINDINGS #5:**

Grievances were reviewed for the prior six months. Concerns related to a lack of resident advocacy were not identified.

The records of 5 residents were reviewed. All 5 resident records documented an appointed Power of Attorney or guardian was in place. One resident's record documented she was her own decision maker prior to being transferred to the hospital. Staff stated the resident designated her daughter as Power of Attorney for a time, and then she was able to make her own decisions so she removed the Power of Attorney. The staff member said the resident contacted the local ombudsman to assist her with regaining her decision making authority, and after she was admitted to the hospital her daughter resumed the Power of Attorney because the resident was no longer able to make her own decisions.

It could not be determined that the facility failed to ensure residents who were not able to speak for themselves had an advocate. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

Amund Evans, Administrator  
January 21, 2020  
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**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj