



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 17, 2015

Clayton South, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. South:

On **September 10, 2015**, a Facility Fire Safety and Construction survey was conducted at **Monte Vista Hills Healthcare Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 30, 2015**. Failure to submit an acceptable PoC by **September 30, 2015**, may result in the imposition of civil monetary penalties by **October 20, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 22, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 22, 2015**. A change in the seriousness of the deficiencies on **October 22, 2015**, 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 **October 22, 2015**, includes the following:

Denial of payment for new admissions effective **December 10, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 10, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 10, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

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

This request must be received by **September 30, 2015**. If your request for informal dispute resolution is received after **September 30, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2015
NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201		
(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
K 000	INITIAL COMMENTS The facility is a single story, type V (III) construction. The building is fully sprinklered with quick response heads. New smoke detectors were installed in 2009. There are multiple exits to grade and a small basement. The facility plans were approved in 1962 and final construction completed in January of 1963. Currently licensed for 113 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 10, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Monte Vista Hills Healthcare Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. RECEIVED SEP 28 2015 FACILITY STANDARDS	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive integrity of the building. Failure to ensure the smoke and fire resistive properties of the facility could allow smoke and dangerous gases to pass freely and add to the rapid development of fire in exposed wall cavities. This deficient practice affected staff and visitors on the date of the	K 012	K-012 1. Penetrations noted in interior walls in the laundry room, and 200 hall biohazard room have been closed or sealed. 2. The Maintenance Director inspected all rooms in the facility by 9/24/15 to ensure no further penetrations were found. 3. The Maintenance Director, or designee, will follow up with any contractor doing work in the facility to ensure all penetrations, if any, are properly sealed. 4. The Administrator, or designee, will conduct a monthly audit for three (3) months, then quarterly audit for three (3) quarters, to walk through the building to inspect penetrations to ensure they are sealed. Results will be reviewed by Q.A.&A. committee until it has been determined by the committee that the systems are effective. 5. PoC - 9/24/15	9/24/15

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

Christine Smith

TITLE

Administrator

(X6) DATE

9/25/15

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.

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

Printed: 09/17/2015
FORM APPROVED
OMB NO. 0938-0391

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K 012	<p>Continued From page 1 survey. The facility is licensed for 113 SNF/NF beds with a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on September 10, 2015 at approximately 11:30 AM, observation of the linen room near the laundry room revealed an approximately 5 inch rectangular hole cut through the the interior of the wall exposing the wall cavity. When asked, the Maintenance Supervisor stated the hole was cut to have access to the water shutoff valve.</p> <p>2.) During the facility tour on September 10, 2015 at approximately 1:30 PM, observation of the biohazard room located in the 200 hallway revealed two 2 inch circular holes cut into the wall exposing the wall cavity. When asked, the Maintenance Supervisor stated the facility was aware of the two holes.</p> <p>Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied</p>	K 012		

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K 012	Continued From page 2 portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided	K 012	<u>K-025</u> 1. Penetrations noted in ceiling of South Dining Area, room 107 bathroom ceiling, clean linen room in 200 hallway ceiling, and MDS office in 200 hallway ceiling have been closed or sealed. 2. The Maintenance Director inspected all rooms in the facility by 9/24/15 to ensure no further penetrations were noted. 3. The Maintenance Director, or designee, will follow up with any contractor doing work in the facility to ensure all penetrations, if any, are properly sealed. 4. The Administrator, or designee, will conduct a monthly audit for three (3) months, then quarterly audit for three (3) quarters, to walk through the facility to inspect penetrations to ensure they are sealed. Results will be reviewed by Q.A.&A. committee until it has been determined by the committee that the systems are effective. 5. PoC 9/24/15	9/24/15
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each	K 025		

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K 025	<p>Continued From page 3</p> <p>floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and the ability to shelter in place. This deficient practice has the potential to affect all residents, staff and visitors on the date of the survey. The facility is licensed for 113 SNF/NF beds and had a census of 40 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 10, 2015 between 10:00 AM and 4:00 PM, observation of the smoke barriers located throughout the facility revealed multiple unsealed penetrations that eliminated the one half hour fire resistance rating. The location and size of the unsealed penetrations were found at the following locations:</p> <ol style="list-style-type: none"> 1.) South Dining Area revealed an approximate 3 inch circular hole in the ceiling. 2.) Bathroom in room 107 revealed an approximate 12" x 7" hole in the ceiling. 3.) Clean Linen room in 200 hallway revealed two holes approximately 2 inches in the ceiling around two conduit pipes. 4.) DNS/MDS office in the 200 hallway revealed 	K 025		

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K 025	Continued From page 5 forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier	K 025	<u>K-029</u> 1. Self-closing devices were installed on doors to the storage room near 130 and the Medical Records storage room to ensure both shut completely and properly. 2. The Maintenance Director inspected all doors requiring self-closure in the facility by 9/24/15 to ensure proper operation. 3. The Maintenance Director, or designee, will follow up with any contractor doing work in the facility to ensure all door requiring self-closure are working properly. 4. The Administrator, or designee, will conduct a monthly audit for three (3) months, then quarterly audit for three (3) quarters, to walk through facility to inspect doors requiring self-closure. Results will be reviewed by Q.A.&A. committee until it has been determined by the committee that the systems are effective. 5. PoC 9/24/15	9/24/15
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation, operational testing, and interview, the facility failed to ensure that hazardous areas were protected with doors that would resist the passage of smoke. Failure to provide doors that would resist the passage of smoke in hazardous areas would allow smoke and dangerous gases to pass freely into corridors during a fire event. This deficient practice affected 12 residents, staff and visitors on the date of the survey. The facility is licensed for 113 SNF/NF beds with a census of 40 on the day of the survey. Findings include: 1.) During the facility tour on September 10, 2015 at approximately 11:15 AM, observation and operational testing of storage room near room 130 revealed the door would not close properly	K 029		

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K 029	<p>Continued From page 6</p> <p>leaving an approximate 1 inch gap between the door frame and leading edge of the door. It was observed the room was larger than 50 ft2 and was used for storage of combustible supplies. When asked, the Maintenance Supervisor stated the facility was unaware of the door not closing properly.</p> <p>2.) During the facility tour on September 10, 2015 at approximately 11:30 AM, observation and operational testing of medical records room located in the 100 hallway revealed the door was not on a self-closure. It was observed the room was larger than 50 ft2 and was used for storage of combustible supplies. When asked, the Maintenance Supervisor stated the room was recently converted to the medical records room and was unaware a door closure was required.</p> <p>Actual NFPA standard:</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops 	K 029		

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K 029	Continued From page 7 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers were installed at the correct height and readily accessible could inhibit their use during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 113 SNF/NF beds with a census of 40 on the day of the survey. Findings include: During the facility tour on September 10, 2015 between 9:00 AM and 4:00 PM, observation of the fire extinguishers located in the areas listed below were installed above the maximum height requirement of 60 inches. When measured, the extinguishers were installed at a height of 64	K 064	<u>K-064</u> 1. The three (3) fire extinguishers near rooms 223, 128 and server room have been replaced with appropriately sized extinguishers that are at, or below, sixty (60) inches above the floor. 2. The Maintenance Director inspected all fire extinguishers in facility to ensure Standard is met by 9/24/15. 3. The Maintenance Director, or designee, will follow up any contractor doing work in the facility to ensure Standard is met. 4. The Administrator, or designee, will conduct a monthly audit for three (3) months, then quarterly audit for three (3) quarters to walk through facility to ensure Standard is met. Results will be reviewed by Q.A.&A. committee until it has been determined by the committee that the systems are effective. 5. PoC 9/24/15	9/24/15

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K 064	<p>Continued From page 8</p> <p>inches above the floor and were all located in vacant standpipe cabinets.</p> <p>200 hallway near room 223 100 hallway near room 128 100 hallway near the server room</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of the height requirements of extinguishers.</p> <p>Actual NFPA standard:</p> <p>NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p>	K 064		