



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 28, 2016

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 22, 2016**, 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 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 **October 11, 2016**. Failure to submit an acceptable PoC by **October 11, 2016**, may result in the imposition of civil monetary penalties by **October 31, 2016**.

Your PoC must contain the following:

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

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 27, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 27, 2016**. A change in the seriousness of the deficiencies on **October 27, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 27, 2016**, includes the following:

Clayton South, Administrator
September 28, 2016
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Denial of payment for new admissions effective **December 22, 2016**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 22, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 22, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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September 28, 2016
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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 11, 2016**. If your request for informal dispute resolution is received after **October 11, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 09/27/2016
FORM APPROVED
OMB NO. 0938-0391

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 09/22/2016
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 22, 2016. 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: Linda Chaney 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.	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are	K 018	K-018 1. Resident room doors for 108, 112, and 137 have been adjusted and close properly. Gap in double doors to Day Room have been covered. 2. The Maintenance Director inspected all doors in the facility by 10/10/16 to ensure no further deficiencies were found. 3. The Maintenance Director, or designee, will follow up with any contractor doing work in the facility to ensure all doors close with appropriate gapping, if any. 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 door gapping and closure to ensure they meet requirements. Results will be reviewed by Q.A.&A. committee until it has been determined by the committee that the systems are effective. 5. PoC - 10/10/16	10/10/16

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

TITLE

(X6) DATE



Administrator

10/10/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	<p>Continued From page 1</p> <p>permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely through smoke barriers. This deficient practice affected 40 residents, staff, and visitors on the date of survey. The facility is licensed for 113 SNF/NF beds with a census of 40 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on September 22, 2016 from approximately 9:00 AM to 12:00 PM, observation and operational testing of the following doors revealed they would not latch:</p> <ul style="list-style-type: none"> - Resident room 108 - Resident room 112 - Resident room 137 (Maintenance Supervisor fixed on the spot) <p>2.) Smoke doors to the Day Room did not close completely leaving an approximately 1/2" gap between the doors.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that</p>	K 018		
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K 018	Continued From page 2 resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018			
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025			

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K 025 SS=F	Continued From page 3 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 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 during a fire event. This deficient practice affected 40 residents, staff, and visitors on the date of 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 22, 2016 from approximately 9:00 AM to 12:00 PM, observation of the Basement revealed several penetrations in the ceiling, including an approximately 4" X 8" hole near the electrical panel. When asked, the Maintenance Supervisor stated the facility was unaware that holes in the basement ceiling needed to be sealed. 2.) During the facility tour on September 22, 2016 from approximately 9:00 AM to 12:00 PM, observation of the Housekeeping closet revealed a 2" circular hole in the wall directly behind the door. When asked, the Maintenance Supervisor stated the facility was unaware of the hole in the wall.	K 025	<u>K-025</u> 1. Penetrations noted in the ceiling of the basement, wall behind door in housekeeping closet, ceiling in resident bathrooms around fan, and in room 217 below sink have been repaired, closed or sealed. 2. The Maintenance Director inspected all rooms in the facility by 10/10/16 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 - 10/10/16	10/10/16	

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K 025	<p>Continued From page 4</p> <p>3.) During the facility tour on September 22, 2016 from approximately 9:00 AM to 12:00 PM, observation of the resident room bathrooms revealed that new ventilation fans had been installed leaving an approximately 2" X 8" hole in the ceiling at each bathroom with the new fans. HVAC tape had been used to cover the holes. When asked, the Maintenance Supervisor stated the facility had used the tape temporarily and were in process of repairing the holes.</p> <p>4.) During the facility tour on September 22, 2016 from approximately 9:00 AM to 12:00 PM, observation of room 217 revealed an approximately 4" X 5" hole in the wall below the sink. When asked, the Maintenance Supervisor stated the facility had replaced a valve and hadn't repaired the hole yet.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p>	K 025			

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K 025	Continued From page 5 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier	K 025			
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit portable space heaters in sleeping areas. Portable space heaters in sleeping areas is considered a significant risk due to the history of fires caused by space heaters. This deficient practice affected 20 residents, staff, and visitors on the day of survey. The facility is licensed for 113 SNF/NF beds with a census of 40 on the date of survey. Findings include:	K 070	<u>K-070</u> 1. Portable electric fireplaces, 2 of them, have had their cords removed, leaving them unusable. 2. The Maintenance Director inspected entire facility by 10/10/16 to ensure no other portable electric fireplaces were present. 3. The Maintenance Director, or designee, will follow up with any new admissions or employees to ensure no portable electric fireplaces are present. 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 portable electric fireplaces are not present. Results will be reviewed by Q.A.&A. committee until it has been determined by the committee that the systems are effective. 5. PoC - 10/10/16	10/10/16	

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K 070	Continued From page 6 During the facility tour on September 22, 2016 from approximately 9:00 AM to 12:00 PM, observation revealed an electric fireplace located in the Activity Room that was not permanently affixed to the wall and hardwired. The Activity Room is only separated from the resident sleep compartment with convenience doors which are open. When asked, the Maintenance Supervisor stated the facility was unaware the electric fireplace was considered a portable heater. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070			
K 147 SS=D	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations were in accordance with the National Electrical Code. This deficient practice affected 2 residents, staff and visitors on the date of survey. The facility is licensed for 113 SNF/NF beds with a census of 40 the day of survey. Findings include: During the facility tour on September 22, 2016, from approximately 9:00 AM to 12:00 PM, the	K 147	<u>K-147</u> 1. Missing blanks inside of breaker panel junction boxes in Maintenance Office and Kitchen have been filled. 2. The Maintenance Director inspected all breaker panel junction boxes in facility to ensure Standard is met by 10/10/16. 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 - 10/10/16	10/10/16	

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NAME OF PROVIDER OR SUPPLIER MONTE VISTA HILLS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1071 RENEE AVENUE POCATELLO, ID 83201
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K 147	<p>Continued From page 7</p> <p>following areas were observed to have missing blanks inside the breaker panel junction boxes to cover openings: Kitchen Maintenance Office</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of the missing blanks.</p> <p>Actual NFPA standard: NFPA 70 National Electrical Code</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p>	K 147		
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