December 29, 2017

Stephen Farnsworth, 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. Farnsworth:

On December 19, 2017, 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 **January 11, 2018**. Failure to submit an acceptable PoC by **January 11, 2018**, may result in the imposition of civil monetary penalties by **January 31, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by , (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 . A change in the seriousness of the deficiencies on , may result in a change in the remedy.

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

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

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

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 January 11, 2018. If your request for informal dispute resolution is received after January 11, 2018, 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 & Construction Program

NE/lj
Enclosures
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
135018

NAME OF PROVIDER OR SUPPLIER
MONTE VISTA HILLS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1071 RENEE AVENUE
POCATELLO, ID 83201

NAME OF PROVIDER OR SUPPLIER
MONTE VISTA HILLS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1071 RENEE AVENUE
POCATELLO, ID 83201

SUMMARY STATEMENT OF DEFICIENCIES
Unless otherwise indicated, the general use of the terms "facility" or "facilities" refers to all provider and suppliers affected by this regulation. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations.

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 partial basement. The facility plans were approved in 1982 and final construction completed in January of 1983. Currently licensed for 113 SNF/NF beds with a census of 47 on the day of survey.

The following deficiencies were cited during the Emergency Preparedness Survey conducted on December 18-19, 2017. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:
Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

1. All deficiencies have now been corrected and the comprehensive emergency preparedness program meets all requirements.
2. All residents, staff, and visitors have potential to be affected by this practice.

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Monte Vista Hills Health Care 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.

Executive Director
11/10/18

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 unless 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.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: HVNX31 Facility ID: MDS01240
If continuation sheet Page 1 of 15
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**IDENTIFICATION NUMBER:** 135018

**NAME OF PROVIDER OR SUPPLIER:** MONTE VISTA HILLS HEALTHCARE CENTER

**ADDRESS:** 1071 RENEE AVENUE
POCATELLO, ID 83201

**STATEMENT OF DEFICIENCIES**

**E 001** Continued From page 1

Program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:

* [For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

* [For CAHs at §485.626:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness Program which includes policies and procedures in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 47 residents, staff and visitors on the date of the survey. The facility is currently licensed for 113 SNF/NF beds and had a census of 47 on the day of the survey.

**CFR reference:** 42 CFR 483.73

**E 018** Procedures for Tracking of Staff and Patients

**E 001**

3. In-service staff on location, function and proper use of the annunciator panel on the generator.

4. Maintenance Supervisor or designee will continue to provide training to staff on the comprehensive emergency preparedness program monthly for three months. The training audits and emergency plan will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.

**FORM APPROVED**

**OMB NO. 0938-0391**

**DATE SURVEY COMPLETED:** 12/19/2017
### Statement of Deficiencies and Plan of Correction

#### Name of Provider or Supplier

**MONTE VISTA HILLS HEALTHCARE CENTER**

#### Statement of Deficiencies

**E 018 Continued From page 2**

<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>E 018</td>
<td>SS=F</td>
<td>CFR(s): 483.73(b)(2)</td>
<td>(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:</td>
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<td>E 018</td>
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<td>(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *</td>
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<td>*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b);] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.</td>
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<td>*[For Inpatient Hospice at §418.113(b)(6);] Policies and procedures. (i) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of</td>
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**1. A sign in sheet log has been created for on-duty staff and has been added to the emergency plan in addition to the tracking of residents via bracelets on 1/8/18.**

**2. All residents, staff, and visitors have potential to be affected by this practice.**

**3. In-service to staff of the updated system for tracking the location of on-duty staff and residents.**

**4. Maintenance Supervisor or designee will provide training to staff on the tracking system for on-duty staff and residents. The training plan will be reviewed monthly by the QAIP committee until it has been determined that the systems are effective.**

**COMPLETION DATE: 2/9/18**
Continued from page 3

communication with external sources of assistance.

(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*For CMHCs at §485.920(b): Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*For OFOs at § 486.360(b): Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*For ESRD at § 494.62(b): Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a current policy for tracking of on-duty staff and sheltered residents during an emergency, or if relocated, a policy for documentation of the receiving facility or other location for those relocated individuals. Lack of a tracking policy has the potential to
Summary Statement of Deficiencies

E 018 Continued From page 4

This deficient practice affected 47 residents, staff and visitors on the date of the survey.

Findings include:

On December 18 - 19, 2017, review of provided records, policies and procedures failed to demonstrate the facility had in place a system to track the location of on-duty staff and sheltered residents during an emergency.

Interview of Administrator, Director of Nursing and Maintenance Supervisor revealed none were aware of any specific policies for the tracking procedure of on-duty staff and residents during an emergency.

Reference:

42 CFR 483.73 (b) (2)

SS=C CFR(s): 483.73(c)(1)

E 030 Names and Contact Information

1. The emergency preparedness communication plan was updated on 1/8/18 and now includes names and contact information for staff, entities providing services, patients' physicians, other facilities, and volunteers.

2. All residents, staff, and visitors have potential to be affected by this practice.

3. In-service to staff of the updated communication plan contents and location of emergency contact information.

4. Maintenance Supervisor or designee will conduct audits of the accuracy of the contact list monthly quarterly. The audits will (continued)
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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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**E 030 Continued From page 5**

1. (iv) Other facilities.
2. (v) Volunteers.

*For RNHCls at §403.748(c):* The communication plan must include all of the following:
1. Names and contact information for the following:
   1. Staff.
   2. Entities providing services under arrangement.
   3. Next of kin, guardian, or custodian.
   4. Other RNHCls.
   5. Volunteers.

*For ASCs at §416.45(c):* The communication plan must include all of the following:
1. Names and contact information for the following:
   1. Staff.
   2. Entities providing services under arrangement.
   3. Patients’ physicians.
   4. Volunteers.

*For Hospices at §418.113(c):* The communication plan must include all of the following:
1. Names and contact information for the following:
   1. Hospice employees.
   2. Entities providing services under arrangement.
   3. Patients’ physicians.
   4. Other hospices.

*For OPOs at §486.360(c):* The communication plan must include all of the following:
1. Names and contact information for the following:
   1. Staff.
   2. Volunteers.

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**E 030** be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.
E 030 Continued From page 6

(ii) Entities providing services under arrangement.
(iii) Volunteers.
(iv) Other OPOs.
(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).
This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to document a communication plan with all required elements. Failure to have a communication plan complete with names and contact information, has the potential to hinder both internal and external emergency response by personnel. This deficient practice had the potential to affect 47 residents, staff and visitors on the date of the survey.

Findings Include:

On December 18 - 19, 2017, review of the facility emergency plan revealed the communication portion of the plan failed to provide the names and contact information for staff, entities providing services under arrangement, resident's physicians, or volunteers.

Interview of the Administrator revealed the communication plan was a work in progress and specific contact information had not yet been added to the plan.

Reference:

42 CFR 483.73 (c) (1)

Information on Occupancy/Needs

CFR(s): 483.73(c)(7)

[(c) The facility must develop and maintain an]
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**
135018

**Name of Provider or Supplier:**
MONTE VISTA HILLS HEALTHCARE CENTER

**Street Address, City, State, Zip Code:**
1071 RENEE AVENUE
POCATELLO, ID 83201

**Summary Statement of Deficiencies**

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Emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

1. A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

2. A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

3. A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

This **Requirement** is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to document a current plan for sharing information on needs, occupancy and its ability to provide assistance with emergency management officials. Lack of a current plan for providing information to emergency personnel on the facility's needs and abilities to provide assistance during an emergency has the potential to hinder response assistance and continuation of care of residents. This deficient practice could potentially affect 47 residents, staff and visitors on the date of the survey.

**Provider's Plan of Correction**

1. A list of potential facility needs and also services the facility can provide has been created and has been provided to community emergency planners and local officials.
2. All residents, staff, and visitors have potential to be affected by this practice.
3. In-service to staff of the updated communication plan contents containing the facility needs and also the services the facility can provide in case of an emergency.
4. Maintenance Supervisor or designee will conduct audits of the accuracy of the facility needs and services that the facility can provider quarterly any changes will be provided to the community emergency planners and local officials.

The audits will be reviewed by the QAPI committee until it has been determined that the systems are effective.

**Completion Date:**
2/9/18
## Findings Include:

On December 18 - 19, 2017, review of the facility emergency plan revealed no indication of what method the facility would use to share information on its needs or capabilities with emergency management officials.

Interview of the Administrator revealed the facility was working with local officials and community emergency planners on what they could offer to the community, but had not yet put the potential facility needs or services the facility could provide in writing.

Reference:

42 CFR 483.73 (c) (7)

### E 037 EP Training Program

**SS=F CFR(s): 483.73(c)(1)**

1. Written training has been added to the emergency preparedness plan. Initial training has been provided to staff on 1/3/18 and training has been implemented into general orientation for new staff on 1/4/18.
2. All residents, staff, and visitors have potential to be affected by this practice.
3. In-service to staff of the emergency preparedness plan and implementation of training into new hire general orientation.
4. Maintenance Supervisor or designee will conduct audits of the training for accuracy for two quarters. The audits will be reviewed by the QAPI committee until it has been determined that the systems are effective.

**DATE SURVEY COMPLETED:** 12/19/2017

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1071 RENEE AVENUE
POCATELLO, ID 83201
### Statement of Deficiencies and Plan of Correction

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<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<td>E 037</td>
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or RHC/FQHC] must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

This is what's in SOM but is missing here.

*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least annually.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:**

135018

**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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<tr>
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<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>E 037</td>
<td>Continued From page 10 (i) After initial training, provide emergency preparedness training at least annually. (ii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</td>
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* [For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.

* [For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following:
  (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of...
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135018  
**State:** ID  

### Summary Statement of Deficiencies

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**Alarm systems and signals and firefighting equipment.**

*For CAHs at §485.625(d):* (1) *Training program.* The CAH must do all of the following:

(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

*For CMHCs at §485.920(d):* (1) *Training.* The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a current emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential...
Continued From page 12

to hinder staff response during a disaster. This
deficient practice affected 47 residents, staff and
visitors on the date of the survey.

Findings include:

On December 18 - 19, 2017, review of the facility
documentation revealed no written training plan
was included in the emergency plan for training
staff on the emergency preparedness policies
and procedures. There was also no
documentation that initial training for all new and
existing staff, individuals providing services under
arrangement or volunteers had taken place.

Interview of the Administrator confirmed the
facility did not currently have a training program
focused on the emergency plan as the facility was
still updating the content.

Reference:

42 CFR 483.73 (d) (1)

E 039
SS=F

(2) Testing. The [facility, except for LTC facilities,
RNHCl's and OPO's] must conduct exercises to
test the emergency plan at least annually. The
[facility, except for RNHCl's and OPO's] must do
all of the following:

[For LTC Facilities at §483.73(d);] (2) Testing.
The LTC facility must conduct exercises to test
the emergency plan at least annually, including
unannounced staff drills using the emergency
procedures. The LTC facility must do all of the
following:]
(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*For RNHCl's at §403.748 and OPOs at §486.360 (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following:

(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
Continued From page 14

(ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a current emergency preparedness testing program. Lack of a current emergency testing program covering the emergency preparedness plan and policies for the facility has the potential to hinder staff response during a disaster. This deficient practice affected 47 residents, staff and visitors on the date of the survey.

Findings Include:

Review of the facility emergency plan on December 18 - 19, 2017, revealed the facility did not have a current emergency preparedness testing program. There was also no documentation that specific testing, to include an annual exercise on the emergency preparedness plan or policies had been conducted.

When asked, the Administrator stated the facility had participated in two community-based tabletop exercises, but had not yet completed the facility full scale annual exercise.

Reference:

42 CFR 483.73 (d) (2)
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 partial basement. The facility plans were approved in 1962 and final construction completed in January of 1963. Currently licensed for 113 SNF/NF beds with a census of 47 on the day of survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on December 18-19, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety & Construction

1. Doors 103, 116, and 130 have all been adjusted, repaired, or replaced to remove excessive gaps. Dutch door leading into the kitchen has been equipped with an astragal.

2. All residents, staff, and visitors have potential to be affected by this practice.

3. In-service to maintenance director that no gaps can exist between doors and door frames greater than ½ inch. Also, in-service to maintenance director that all Dutch doors must be equipped with an astragal, rabbet or (continued)

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Monte Vista Hills Health Care 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.

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FACILITY STANDARDS

1. Doors 103, 116, and 130 have all been adjusted, repaired, or replaced to remove excessive gaps. Dutch door leading into the kitchen has been equipped with an astragal.

2. All residents, staff, and visitors have potential to be affected by this practice.

3. In-service to maintenance director that no gaps can exist between doors and door frames greater than ½ inch. Also, in-service to maintenance director that all Dutch doors must be equipped with an astragal, rabbet or (continued)
**K 363**  bevel between the meeting edges of the upper and lower edges.

4. Maintenance Supervisor or designee will conduct an audit of all doors to ensure no excessive gaps exist weekly for four weeks and monthly for three months. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.

Findings include:

During the facility tour on December 19, 2017 from approximately 1:30 PM to 3:30 PM; observation and operational testing of room doors
Continued From page 2

103, 116, and 130 revealed gaps between the doors and the door frames ranging in size from 5/8 inch to 3/4 inch. Upon further evaluation of the door to room 130 revealed substantial damage to the door and door assembly that should require replacement.

Upon further investigation of the kitchen Dutch door leading off the main corridor revealed the door was not equipped with an astragal to restrict the passage of smoke, flame, or gases during a fire, and also to ensure that the lower leaf of the door closes in conjunction with the upper leaf. When asked, Maintenance Supervisor acknowledged the findings.

Actual NFPA References:

NFPA 101, 19.3.6.3.2 (2)
In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, the door construction materials requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

19.3.6.3.13 Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the following criteria:
(1) Both the upper leaf and lower leaf are equipped with a latching device.
(2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel.
(3) Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA 80, Standard for Fire Doors and Other...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135018

**Name of Provider or Supplier:** MONTE VISTA HILLS HEALTHCARE CENTER

**Street Address, City, State, Zip Code:** 1071 RENEE AVENUE, POCATELLO, ID 83201

**ID Prefix/Tag:**

<table>
<thead>
<tr>
<th>ID Prefix/Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 363</td>
<td>Continued From page 3 Opening Protective. Subdivision of Building Spaces - Smoke Barrier Construction: Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at a atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke barrier doors would close properly to protect smoke compartments Failure to ensure that smoke compartment doors close completely would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 47 of 47 residents, staff and visitors on the day of the survey. Findings include: During the facility tour on December 19, 2017 from approximately 1:30 PM to 3:30 PM; operational testing of the smoke barrier doors located between room 137 and laundry room revealed the doors would not close properly due to improper installation.</td>
<td>K 363 1. Smoke barrier door between room 137 and laundry room was repaired on 12/26/17 to close properly. 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to maintenance director that all smoke doors must close properly. 4. Maintenance Supervisor or designee will conduct an audit of all smoke barrier doors to ensure proper closure weekly for four weeks and monthly for three months. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.</td>
<td>2/9/18</td>
</tr>
<tr>
<td>K 372</td>
<td>Subdivision of Building Spaces - Smoke Barrier Construction: Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at a atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke barrier doors would close properly to protect smoke compartments Failure to ensure that smoke compartment doors close completely would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 47 of 47 residents, staff and visitors on the day of the survey. Findings include: During the facility tour on December 19, 2017 from approximately 1:30 PM to 3:30 PM; operational testing of the smoke barrier doors located between room 137 and laundry room revealed the doors would not close properly due to improper installation.</td>
<td>K 372 1. Smoke barrier door between room 137 and laundry room was repaired on 12/26/17 to close properly. 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to maintenance director that all smoke doors must close properly. 4. Maintenance Supervisor or designee will conduct an audit of all smoke barrier doors to ensure proper closure weekly for four weeks and monthly for three months. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.</td>
<td>2/9/18</td>
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</table>
### K 372
- Continued From page 4
- to one (1) leaf that was catching on the upper door frame leaving an approximate 3 inch gap. This finding was acknowledged by the Maintenance Supervisor.

**Actual NFPA standard:**

**NFPA 101**

19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1.2-hour Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.

**8.5 Smoke Barriers**

8.5.1* General. Where required by Chapters 11 through 43, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke.

8.5.2* Continuity.

8.5.2.1 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 by use of a combination thereof.

### K 511
- Utilities - Gas and Electric
- **CFR(s): NFPA 101**

**Utilities - Gas and Electric**

Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no...
## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135018

**Name of Provider or Supplier:** MONTE VISTA HILLS HEALTHCARE CENTER

### Summary Statement of Deficiencies

**ID** (4) Prefix Tag | **Tag** | **Provider's Plan of Correction** (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency) |
--- | --- | --- |
K 511 | Continued From page 5 | all appliances are to be plugged in directly into an outlet. all electrical appliances to be inspected for proper installation. 4. Maintenance Supervisor or designee will conduct an audit of all electrical systems and appliances to ensure proper wall connection weekly for four weeks and monthly for three months. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective. |

This **Requirement** is not met as evidenced by:

Based on observation and interview, the facility failed to ensure that electrical systems were installed and used in accordance with NFPA 70. Failure to ensure proper electrical installations and use could result in electrocution or fire. This deficient practice affected 47 residents, staff and visitors on the date of the survey.

Findings include:

During the facility tour on December 19, 2017 from approximately 1:30 PM to 3:30 PM, observation of the facility laundry room revealed two full sized washing machines were plugged into a RPT (Relocatable Power Tap). When asked, the Maintenance Supervisor stated the outlet behind the washers was not working and every time they replaced it, it popped the breaker, so they were using the RPT to access a different outlet for the washing machines.

**Actual NFPA Standard:**

NFPA 70

400.8 Uses Not Permitted.

Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:

1. As a substitute for the fixed wiring of a structure
2. Where run through holes in walls, structural
### Continued From page 6

1. Contractor has been scheduled and a remote manual stop for the generator will be installed at South Nurse Station.
2. All residents, staff, and visitors have potential to be affected by this practice.
3. In-service staff on location, function and proper use of the manual stop on the generator.
4. Maintenance Supervisor or designee will conduct a test monthly for three months to ensure manual emergency stop is functioning properly. The test results will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.

**Findings include:**

During the facility tour conducted on December 19, 2017 from approximately 1:30 PM to 3:30 PM,
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135018

**Building:** 01 - Entire Building

**Date Survey Completed:** 12/19/2017

**Name of Provider or Supplier:** Monte Vista Hills Healthcare Center

**Street Address, City, State, Zip Code:**

- 1071 Renee Avenue
- Pocatello, ID 83201

#### Summary Statement of Deficiencies

**K 911**

- Continued From page 7
- Observation revealed the facility did not provide a remote manual stop switch for the EES generator. When asked, the Maintenance Supervisor stated the facility was not equipped with a remote stop switch.

**Actual NFPA standard:**

- **NFPA 110**
  - 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.
  - 5.6.5.6.1 The remote manual stop station shall be labeled.

- **NFPA 99**
  - 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (See Table)

**K 916**

- **Electrical Systems - Essential Electric System**
- **CFR(s): NFPA 101**
- **Alarm Annunciator**

  A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.

  **6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)**

This REQUIREMENT is not met as evidenced

<table>
<thead>
<tr>
<th>K 911</th>
<th>K 916</th>
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<tr>
<td><strong>ID</strong></td>
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<tr>
<td><strong>Compliance Date</strong></td>
<td><strong>Completion Date</strong></td>
</tr>
<tr>
<td><strong>1. Contractor has been scheduled and an annunciator panel for the generator will be installed at South Nurse Station.</strong></td>
<td>2/9/18</td>
</tr>
<tr>
<td><strong>2. All residents, staff, and visitors have potential to be affected by this practice.</strong></td>
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<tr>
<td><strong>3. In-service staff on location, function and proper use of the annunciator panel on the generator.</strong></td>
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<tr>
<td><strong>4. Maintenance Supervisor or designee will conduct a test weekly for four weeks and monthly for three months to ensure annunciator panel is functioning properly.</strong></td>
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</table>
### Summary Statement of Deficiencies

Based on observation and interview, the facility failed to ensure the EES (Essential Electrical System) was installed in accordance with NFPA 99. Failure to provide an alarm annunciator for the EES could hinder early notification of equipment failures, leaving the facility without emergency power during an outage. This deficient practice affected 47 residents, staff and visitors on the date of the survey.

Findings include:

During the facility tour conducted on December 19, 2017, from approximately 1:30 PM to 3:30 PM, observation of the work stations throughout the facility, did not reveal an alarm annunciator for the EES. When asked, the Maintenance Supervisor stated that he was not aware of an alarm panel, or other device which would indicate the facility was under auxiliary power (generator) during a power outage.

Actual NFPA standard:

- **NFPA 99**
  - Chapter 6 Electrical Systems
  - 6-4 Essential Electrical System Requirements - Type 1.
  - 6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows:
    1. Individual visual signals shall indicate the

### Provider's Plan of Correction

The test results will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.
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<th>K 916</th>
<th>Continued From page 9 following:</th>
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<tbody>
<tr>
<td></td>
<td>(a) When the emergency or auxiliary power source is operating to supply power to load</td>
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<td></td>
<td>(b) When the battery charger is malfunctioning</td>
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<tr>
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<td>(2) Individual visual signals plus a common audible signal to warn of an engine generator alarm condition shall indicate the following:</td>
</tr>
<tr>
<td></td>
<td>(a) Low lubricating oil pressure</td>
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<td>(b) Low water temperature (below that required in 6.4.1.1.11)</td>
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<td></td>
<td>(c) Excessive water temperature</td>
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<td>(d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply</td>
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<td>(e) Overcrank (failed to start)</td>
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<td>(f) Overspeed</td>
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