

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

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 135018

**(X2) MULTIPLE CONSTRUCTION**  
A. BUILDING 01 - ENTIRE BUILDING

**(X3) DATE SURVEY COMPLETED:** R 03/08/2019

**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**  
A. BUILDING 01 - ENTIRE BUILDING

**(X5) COMPLETION DATE**

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**SUMMARY STATEMENT OF DEFICIENCIES**  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID PREFIX TAG**  
A. BUILDING 01 - ENTIRE BUILDING

**PROVIDER'S PLAN OF CORRECTION**  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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**INITIAL COMMENTS**

On 03/08/19 an off-site follow-up survey was conducted, substantiating compliance for deficiencies found during the annual Fire/Life Safety survey conducted on 1/29/19. Monte Vista Healthcare Center was determined to be in substantial compliance with all Life Safety Code standards at this time.

The surveyor completing this survey was:

Sam Burbank  
Health Facility Surveyor  
Facility Fire/Safety and Construction

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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**  
**TITLE**  
**(X6) DATE**

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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.
**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>Provider/Supplier/CLIA Identification Number:</th>
<th>Multiple Construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>135018</td>
<td>A. Building __________</td>
</tr>
<tr>
<td></td>
<td>B. Wing ______________</td>
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</tbody>
</table>

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

**Initial Comments**

On 03/08/19 an off-site follow-up survey was conducted, substantiating compliance for deficiencies found during the annual Emergency Preparedness survey conducted on 1/29/19. Monte Vista Hills Healthcare Center was determined to be in substantial compliance with all Emergency Preparedness standards at this time.

The surveyor completing this survey was:

Sam Burbank  
Health Facility Surveyor  
Facility Fire/Safety and Construction

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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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**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**