



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 5015

July 10, 2013

Josiah C. Dahlstrom, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201

Provider #: 135018

Dear Mr. Dahlstrom:

On **June 26, 2013**, 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, and a similar State Form 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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces

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provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 23, 2013**. Failure to submit an acceptable PoC by **July 23, 2013**, may result in the imposition of civil monetary penalties by **August 12, 2013**.

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.

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 **July 26, 2013**, (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 **July 26, 2013**. A change in the seriousness of the deficiencies on **July 26, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 26, 2013**, includes the following:

Denial of payment for new admissions effective **September 21, 2013**.
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

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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 **December 21, 2013**, 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 **June 26, 2013**, 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>

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

BFS Letters (06/30/11)

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

This request must be received by **July 23, 2013**. If your request for informal dispute resolution is received after **July 23, 2013**, 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,

A handwritten signature in black ink, appearing to read 'M. Grimes', with a long horizontal flourish extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/dmj
Enclosures

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

Printed: 07/01/2013
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 06/26/2013
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	<p>INITIAL COMMENTS</p> <p>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.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 26, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p style="text-align: right;">RECEIVED JUL 22 2013 FACILITY STANDARDS</p>	
K 017 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p>	K 017	<p>K 017</p> <p>A. Corrective Actions: Four (4) smoke detection devices were added to the dining room.</p> <p>B. Identification of others affected and corrective actions: All residents using the dining room for meal service could be affected by the lack of smoke detectors, with the potential to affect other residents residing near the dining room.</p> <p>C. Measures to ensure that the deficient practice does not happen again:</p>	

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

Joshua Dahlstrom

TITLE

Executive Director

(X6) DATE

7/16/13

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 017	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation and staff interview during a tour of the facility on 06/26/13, the facility failed provide early detection to protect corridors and expedite resident movement to a safe area.. This potentially exposed residents to a smoke or fire environment. The deficient practice would affect all residents, visitors, and staff in one of seven compartments. The facility has the capacity for 113 beds with a census of 48 on the day of the survey.</p> <p>Findings include:</p> <p>Observation on 06/26/13 at 11:05 a.m., revealed there was no fire alarm system smoke detection devices in the dining room that is open to the corridor. Interview with the Maintenance Supervisor on 06/26/13 at 11:05 a.m., revealed that the facility was not aware that smoke detection devices were required in spaces open to the corridor..</p> <p>The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on June 26, 2013.</p> <p>Actual NFPA standard(s): 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with</p>	K 017	<p>Four smoke detection devices were installed in the area with the noted concern. The entire facility was audited with the health facility surveyor and maintenance director at the time of the survey and no other areas were noted to be of concern.</p> <p>D. Monitor corrective actions: The area of concern has been fixed and all other areas in the facility were audited by the Health Facility Surveyor and our Maintenance Director, thus removing the need for further monitoring.</p> <p>E. Corrective Actions will be completed:</p>	7/03/13

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K 017	Continued From page 2 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits	K 017			
K 029 SS=F	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 and interview, it was determined that the facility did not ensure that	K 029	K 029 A. Corrective Actions: The inoperative self-closing device to the corridor door to the supply/housekeeping storage room was replaced with an operative self-closing device on 6/27/13. B. Identification of others affected and corrective actions: All residents residing on the South hall have the potential to be affected by the non operational self-closing door. C. Measures to ensure that the deficient practice does not happen again: All laundry and housekeeping staff have been in-serviced regarding the need for a		

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K 029	<p>Continued From page 3</p> <p>hazardous areas were constructed with self-closing doors. Hazardous area doors that do not self-close can allow smoke and fire gasses to enter the corridor in the event of a fire. The deficient practice affected one of seven smoke compartments, staff and 8 residents. The facility has the capacity for 113 beds with a census of 48 residents on the day of survey.</p> <p>Findings include:</p> <p>Observation on 06/26/13 at 09:46 a.m., revealed that the corridor door to the supply/housekeeping storage room was not equipped with an operative self-closing device. The room was in excess of 50 square feet and was being used for storage of combustible paper products on open shelving. Interview with the Maintenance Supervisor on 06/26/13 at 09:46 a.m., revealed that the facility was not aware of the inoperative self-closing device.</p> <p>The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on June 26, 2013.</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</p>	K 029	<p>self-closing door for hazardous areas and the need to ensure the doors continue to function with the current self-closing devices that are in place. Any concerns will be given to the Maintenance Director to be addressed immediately.</p> <p>D. Monitor corrective actions: The Maintenance Director will audit all self closing doors on a monthly basis over the next quarter and quarterly thereafter. The audits will begin 7/16/13 and will be reviewed by the QA committee as often as concerns are noted to ensure ongoing compliance.</p> <p>E. Corrective Actions will be completed:</p>	7/16/13

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K 029	Continued From page 4 areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), 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. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>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.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 26, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p style="text-align: right;">RECEIVED JUL 22 2013 FACILITY STANDARDS</p>	
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>1.) K017 Corridors</p>	C 226	<p>C 226</p> <ol style="list-style-type: none"> 1. Please refer to K 017. 2. Please refer to K 029. 	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Josiah Dahlstrom

TITLE

Executive Director

(X6) DATE

7/16/13

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C 226	Continued From Page 1 2.) K029 Hazardous Area	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.