



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  
Bosco, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

**CERTIFIED MAIL: 7012 3050 0001 2125 5990**

November 18, 2014

Richard F. Cartney, Administrator  
Monte Vista Hills Healthcare Center  
1071 Renee Avenue  
Pocatello, ID 83201-2508

FILE COPY

Provider #: 135018

Dear Mr. Cartney:

On **November 5, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 17, 2014**. However, based on our on-site follow-up revisit conducted **November 5, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

- F157 -- S/S: D -- 42 CFR §483.10(b)(11) -- Notify of Changes (Injury/Decline/Room, Etc)**
- F226 -- S/S: D -- 42 CFR §483.13(c) -- Develop/Implment Abuse/Neglect, Etc Policies**
- F246 -- S/S: D -- 42 CFR §483.15(e)(1) -- Reasonable Accommodation of Needs/Preferences**

In addition, a Complaint Investigation survey was conducted in conjunction with the on-site follow-up.

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. Waiver renewals may be requested on the Plan of Correction.

Richard F. Cartney, Administrator  
November 18, 2014  
Page 2 of 4

After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed. The findings to the Complaint Investigation is being processed and will be sent to your facility under separate cover.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 1, 2014**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

As noted in the letter of **September 23, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **September 12, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of

Richard F. Cartney, Administrator  
November 18, 2014  
Page 3 of 4

Payment for New Medicare and Medicaid Admissions (DPNA) and termination of the provider agreement on **March 12, 2015**, if substantial compliance is not achieved by that time. On October 2, 2014, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after October 17, 2014
- A 'per instance' civil money penalty of \$2500.00.

A follow-up letter from CMS, dated October 22, 2014, constituted the formal notification for the imposition of the CMP.

**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.**

STATE ACTIONS effective with the date of this letter (November 18, 2014): none

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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)

2001-10 Long Term Care Informal Dispute Resolution Process

Richard F. Cartney, Administrator  
November 18, 2014  
Page 4 of 4

2001-10 IDR Request Form

This request must be received by **December 1, 2014**. If your request for informal dispute resolution is received after **December 1, 2014**, 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 on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and cursive.

LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>	
(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
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the onsite follow up and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Linda Kelly, RN</p> <p>The survey team entered the facility on November 3 and exited on November 5, 2014</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed</p> <p>F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse</p>	{F 000}	<p>Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.</p> <p>F 157</p> <p>The facility has corrected the alleged deficient practice affecting Resident # 1 by notifying Resident #1's physician of her lab value.</p> <p>The facility recognizes that all residents who have labs ordered have a potential to be affected by a similar alleged deficient practice. Therefore, the facility has implemented the following measures to ensure that alleged deficient practice will not reoccur: (1) DNS and Administrator provided in-service training for nursing staff on 11/7/2014 regarding the importance of notifying physicians of their patients' lab results. (2) The DNS implemented a lab tracking tool to monitor nurses' compliance with timely notification to physicians of their patients' lab results. (3) Facility clinical team reviews all ordered labs during the morning clinical meeting to ensure appropriate physician notification.</p> <p>The facility is monitoring the effectiveness of these measures daily for at least 1 month, after which, if the facility Q. A. &amp; A. Committee finds that the daily monitoring has been effective, it may recommend a reduction of monitoring to twice a week for 1 additional month. Thereafter, periodic monitoring will be performed by DNS/designee and reported to the facility Q. A. &amp; A. Committee.</p> <p>Any variances will be followed up with in-servicing/education to achieve compliance.</p> <p>Results of the monitoring will be presented through the QA process and all concerns will be addressed with the administrator.</p> <p>POC date: 12/2/2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE ADMINISTRATOR (X6) DATE 11/28/14

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

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>		
(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	
F 157	<p>Continued From page 1</p> <p>consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the physician was notified of a subtherapeutic Dilantin (an anticonvulsant medication) level for 1 of 4 sample residents (#1) reviewed for physician notification. Nine days after the facility failed to report Resident #1's subtherapeutic Dilantin level to the physician, the resident had a seizure, fell, sustained a laceration above the left eye, and had more seizures. Findings included:</p> <p>Resident #1 was admitted to the facility in 1997 and readmitted in 2008 with multiple diagnoses which included seizures, epilepsy, and cerebellar atrophy.</p> <p>The resident's care plan identified "Has Seizure Disorder" as a focus area on 3/13/14.</p>	F 157			

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

PRINTED: 11/17/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/05/2014
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	
F 157	<p>Continued From page 2</p> <p>Interventions included, "Give seizure medication as ordered...Obtain and monitor lab/diagnostic work as ordered. Report results to MD [physician]."</p> <p>The resident's Order Summary Report of active orders included: * "Dilantin (Phenytoin) Suspension 175 mg [milligrams] = 7 cc [cubic centimeters] By mouth (PO) Every evening...[for] EPILEPSY..." It was started 6/27/13; and, * "...Phenytoin level to be drawn every 6 months, in April and October...starting on the 7th for 1 day..." It was ordered 8/8/14 and started 10/7/14.</p> <p>The resident's MAR for October 2014 documented that the aforementioned Dilantin was administered to the resident daily at 6:30 p.m. from 10/1 through 10/26/14.</p> <p>A laboratory (lab) report, dated 10/7/14, documented the resident's Dilantin level was 7.8, "L [low]," and the reference range for Dilantin was 10.0-20.0. Noted in handwriting on the report was, "Faxed 10/8/14 [and initials]."</p> <p>Progress Notes (PNs), dated 10/2/14 through 11/5/14 at 8:06 a.m., documented the resident had a seizure which lasted 45 seconds on 10/3/14, the ordered lab tests were drawn on 10/7/14, and an e-MAR entry was made in the afternoon on 10/7/14. However, there were no other PNs until 10/16/14 at 10:05 a.m. when the resident had a seizure, fell, sustained a laceration above the left eye, and had more seizures.</p> <p>The PN on 10/16/14 at 10:05 a.m., documented, "...called to another resident's room and found the resident [Resident #1] having a seizure on the</p>	F 157			

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE</b> <b>POCATELLO, ID 83201</b>		
(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	
F 157	<p>Continued From page 3</p> <p>floor...non-responsive and bouncing her feet rhythmically. Resident had been chatting with a friend when the seizure occurred...was responsive at 1009 [10:09 a.m.] hours, shortly after she had another seizure... Patient sustained a laceration superior to her L [left] eye, that appears to have occurred when she fell out of her wheel chair...when the seizure first occurred. Bleeding controlled with gauze. Patient had several seizures with periods of responsiveness in-between...notified [physician's name]... [Physician's name] asked to be updated if resident did not improve postictally [after seizure], and asked for steri-strips to be placed. Seizure activity stopped around 1045 [10:45 a.m.] hours..."</p> <p>A Root Cause of This Fall form attached to a Fall scene Investigation Report, dated 10/16/14 at 10:05 a.m., documented, "Conclusion: Need to check Dilantin levels &amp; update MD of results. [and] Additional Care Plan / Additional Interventions: [check] Dilantin levels as part of fall prevention."</p> <p>On 11/4/14 at 4:20 p.m., the DNS was asked when the resident's physician was notified of the 10/7/14 subtherapeutic Dilantin level. Clinical Resource Nurse (CRN) #2 was present during the interview. The DNS reviewed the aforementioned lab report and PNs, acknowledged the handwritten "faxed" entry on the lab report, commented there were no PNs between 10/7/14 and 10/16/14, then he stated, "I don't know." The DNS said he would do more research and get back with the surveyor.</p> <p>On 11/5/14 at 9:15 a.m., the DNS provided Fall Committee IDT (Interdisciplinary Team) Progress</p>	F 157			

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE</b> <b>POCATELLO, ID 83201</b>		
(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	
F 157	<p>Continued From page 4</p> <p>Notes for 4/29/13 through 10/21/14 and said he was still looking for documentation regarding the 10/7/14 Dilantin level.</p> <p>Note: Informational Letter #2000-01 from the Bureau of Facility Standards (BFS,) dated March 1, 2000, addressed to: "All Idaho Nursing Facilities," SUBJECT: "Fax Notification of Physicians" stated, "...1. Is a fax considered to meet the requirement for immediately consulting with the physician? ANSWER: Not necessarily. 2. Is it appropriate to assume that if the physician does not respond to the fax, the facility has met their obligation of consulting with the physician and no further action is needed? ANSWER: No. Unless the physician responds to the fax immediately, there is no way to ensure that the physician is in the office and/or that he/she received the fax. There is no assurance that the fax was received unless the office is contacted to confirm the fax was received and relayed to the physician. The Department's position (in bold) is that an unconfirmed (underlined) fax will not be considered physician notification until such time as the physician makes return contact to the facility. In other words, if the physician does not respond to the fax, the Department will not assume that the physician received the fax and choose not to answer it. Instead the Department will consider this a finding of noncompliance with F157..."</p> <p>On 11/5/14 at 10:30 a.m., the Administrator and DNS were informed of concerns regarding the physician notification issue for Resident #1.</p> <p>On 11/6/14 at 1:18 p.m., the BFS received a 2 pages from the facility via fax. Page 1, a cover letter, stated, "[Physician's name] sent us a fax</p>	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 11/05/2014
--	--	--	---

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
--------------------	--	---------------	---	----------------------

F 157	<p>Continued From page 5 regarding her notification of labs..." Page 2, a handwritten note by the resident's physician stated, "[Resident's name] labs in October 2014 were run by [a local medical center laboratory]. I always get a copy from [medical center's initials] same day as results are reported. I don't know for sure, nor do I have documentation of, exact day/time [facility's initials] nurses faxed results to me - but I did get results for certain, same day as labs were done."</p> <p>This additional information did not relieve the facility of the responsibility to ensure the resident's physician was notified of the subtherapeutic Dilantin level and to determine the physician's response.</p>	F 157	<p>F 226</p> <p>The facility addressed the alleged deficient practice for residents #11, #14 and #17 by having the facility Social Worker visit with each of these residents individually to verify that no new concerns were noted.</p> <p>The facility recognizes that other residents may potentially be affected by a similar alleged deficient practice. Facility has taken the following steps to prevent additional residents from being negatively affected by recurrence of the alleged deficient practice:</p> <p>On 11/7/2014 Administrator and DNS provided in-service training during the staff meeting on the topics of abuse identification, abuse prevention and abuse reporting. Facility has implemented protocols to ensure that all allegations of abuse will be investigated thoroughly and reported appropriately to the Idaho Bureau of Facility Standards.</p> <p>The effectiveness of these interventions will be monitored daily, on normal business days, by the IDT during the morning meeting. This daily monitoring will continue for at least 1 month and, if the Q. A. &amp; A. committee feels that it is effective at that point, monitoring will occur 2 times weekly for 1 additional month. Following this monitoring period, facility IDT will continue monitoring during morning meeting as needed.</p> <p>Effectiveness of monitoring will be discussed by the facility Q. A. &amp; A. Committee. Administrator will ensure follow through and implementation of any needed changes identified by the Committee.</p> <p>POC date: 12/2/2014</p>	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, review of abuse policies and procedures, and review of abuse investigation reports, it was determined the facility failed to follow its abuse policies and procedures to ensure all allegations of abuse were thoroughly investigated. The facility did not: * Ensure that all allegations and investigation results were reported to the State Survey Agency/ Bureau of Facility Standards (BFS) in accordance with state law;</p>	F 226		

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>		
(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	
F 226	<p>Continued From page 6</p> <p>* Ensure residents and/or resident representatives were informed of the allegations and outcomes of investigations; and,</p> <p>* Ensure all witnesses, including the residents, were interviewed and written statements obtained.</p> <p>This was true for 3 of 3 sampled residents (#s 11, 14, and 17). Failure to operationalize the facility's abuse policies and procedures placed these three residents, and all other residents who lived in the facility, at risk for physical and/or psychological harm. Findings include:</p> <p>BFS Informational Letter 2014-04 documented: "...The facility must attempt to get a signed, written statement from the accused" and "...All allegations must be immediately reported to the facility's Administrator and to the Department's hotline...'Immediately' means as soon as reasonably possible, and no later than 24 hours from the discovery of the incident. Fax the completed investigation to the survey agency within five (5) working days..."</p> <p>The facility's Abuse Investigation policy dated May 2007, documented the investigation would consist of the following: interviews with the person(s) reporting the incident; witnesses to the incident; staff members having contact with the resident during the period/shift of the alleged incident; and interview with the resident's roommate, family members, and visitors; and the resident if possible. Social Services was to interview the resident, assess the resident for his/her reaction to the situation, and provide ongoing monitoring until the resident indicated verbally or non-verbally he/she felt comfortable and safe. The policy stated the Administrator was to keep the resident or his/her representative</p>	F 226			

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

PRINTED: 11/17/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/05/2014
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	
F 226	<p>Continued From page 7</p> <p>informed of the progress of the investigation. In addition, Section 5 documented, "the investigation form and written statements from all persons involved would be forwarded to the Administrator within 24 hours of the occurrence" and the facility was to, "Report alleged violation(s), the result of the investigation, and appropriate corrective action to the State Agency [BFS]." An initial report was to be reported to BFS by the next business day by telephone and the results of all investigations would be reported within five (5) calendar days of the incident.</p> <p>1. Resident #17 was admitted to the facility on 3/25/07 and re-admitted on 9/26/11 with diagnoses of anoxic brain damage, anxiety, shortness of breath, and generalized pain.</p> <p>The current Quarterly MDS, dated 8/28/14, coded the resident was cognitively impaired.</p> <p>The care plan dated 3/7/14, documented the resident was at risk for impaired cognitive function/thought process, short term memory loss, impaired decision making, and he calls out repetitively, is restless, and anxious. Interventions included: "allow resident extra time to make decisions; attempt to meet needs in a timely manner and anticipate needs to avoid/decrease verbal outbursts; when yelling out/asking repetitive questions, respond to him promptly and acknowledge him face to face."</p> <p>An Investigation Report, dated 10/23/14 documented, "staff member indicated they had heard nurse [LN #5] 'yelling' at the resident in the hallway. They said that they did not hear what he [LN #5] said. Resident had been yelling, which is his pattern when he wants something." The</p>	F 226			

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE</b> <b>POCATELLO, ID 83201</b>		
(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	
F 226	<p>Continued From page 8</p> <p>assessment of the resident documented the resident had, "no injuries or psychosocial indications." However, the report did not document how that was determined. The report documented the resident, "was unable to assist in the investigation due to cognition abilities." The facility identified the contributing factor to be, "Resident has TBI [traumatic brain injury] and does not recognize when he is yelling out for help. Staff go to him and see what it is that he is needing." Specific recommendations/interventions taken to prevent reoccurrence were, "Staff member [LN #5] needs to be aware how loud his voice is when communicating with residents. He has been educated on this." The summary and outcome of the investigative findings documented, "No care plan interventions need to be addressed at this time."</p> <p>On 11/4/14 at 10:30 AM the DNS (Director of Nursing Services), LSW (Licensed Social Worker), CRN (Clinical Regional Nurse), and the Administrator were interviewed. When asked what the findings/conclusions of the investigation were, the Administrator stated, "I should have typed out the summary, but I didn't. I gave you the summary of investigation verbally." The investigation report did not document a date and time when the Administrator was notified nor did it document that the resident's representative or BFS had been notified. When asked if the LSW had interviewed the resident, assessed the resident for his/her reaction to the situation, and provided ongoing monitoring until the resident indicated verbal or non-verbal indications of comfort and safety, the LSW stated, "I don't recall talking to [Resident #17] on that day. I assumed someone had talked to him." The Administrator</p>	F 226			

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE</b> <b>POCATELLO, ID 83201</b>		
(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	
F 226	<p>Continued From page 9</p> <p>stated, "I thought someone had interviewed the resident, but no one had. We should have talked to him."</p> <p>The Investigation report identified two other residents were present during the incident. One of the residents was cognitively intact and the other had some cognitive impairment. When asked if those residents or any other residents receiving care from LN #5 had been interviewed, the Administrator stated, "No, they are all cognitively impaired on that end." When asked why the witness statements were not signed by the witnesses the Administrator said, they were present while he was typing their statements and felt like that was enough. When asked if the resident's representative had been notified about the incident, the Administrator said, "No." The Administrator was unable to provide an answer when asked why the facility's policy and procedures for Abuse Investigation was not followed. When asked if the incident was reported to the Bureau of Facility Standards, the Administrator stated it had not because he was, "able to complete the investigation with in six hours and determined abuse had not occurred."</p> <p>2. Resident #11 was admitted to the facility on 5/16/12 with diagnoses of hemiplegia to non-dominant side related to cerebrovascular accident (CVA), epilepsy, vascular dementia, bipolar disorder, and depression.</p> <p>The current Quarterly MDS, dated 10/15/14, coded the resident was cognitively intact.</p> <p>The care plan, dated 2/28/14, identified the resident was at risk for communication problems related to CVA and mood problem/altered</p>	F 226			

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE</b> <b>POCATELLO, ID 83201</b>		
(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	
F 226	<p>Continued From page 10</p> <p>psychosocial well-being related to depression and bipolar disorder. Interventions included, "monitor and document the resident's frustration level and to wait 30 seconds before providing resident with word and validate message by repeating aloud; monitor behavior episodes and attempt to determine underlying cause; consider location, time of day, persons involved, and situations; offer hard suckers for her to suck on as she desires; and allow to wander hallways as she desires-redirect as needed for safety and to ensure that she does not invade others personal space."</p> <p>An Investigation Report, dated 10/23/14, reviewed for Resident #17 (see findings in example #1) documented the following related to Resident #11. Resident #11 approached a staff member, LN #5, and tugged on the LN's shirt. The LN turned to Resident #11 and, "told her loudly that she would have to wait her turn." The witness stated, "She thought [LN #5] had done so in a tone that was not very nice." There was no investigation report completed for Resident #11 related to this incident.</p> <p>On 11/30/14 at 10:50 AM, when asked why the facility had not completed an investigation report for Resident #11, the Administrator stated there were two incidents, with two different residents that occurred simultaneously on 10/23/14 and he had included some information related to both residents on the same report. The surveyor asked how was it determined which information was documented for which resident. The Administrator indicated he could not tell either and stated, "I see what you mean." When asked if the incident was reported to BFS, the Administrator stated it had not because he was</p>	F 226			

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

PRINTED: 11/17/2014  
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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R-C 11/05/2014
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	
F 226	Continued From page 11 able to, "complete the investigation within six hours and determined abuse had not occurred."  3. Resident #14 was admitted to the facility on 10/14/14 with multiple diagnoses including the need for rehabilitation and dementia.  On 11/3/14 at 1:45 PM, a facility's Investigation Report dated 10/24/14, for Resident #14 was received and reviewed. The investigation detailed an allegation of physical abuse, where an identified CNA was accused of throwing an adult brief which hit Resident #14's face.  On 11/3/14 at 1:50 PM, the Administrator informed the surveyor, the investigation nor the results of the investigation, were reported to the state agency because they were able to determine within 6 hours of receipt of the allegation that abuse did not occur in this instance.  On 11/3/14 at 3:45 PM, the accused, CNA #1 was interviewed. When asked if she was asked to provide a written statement, she said she was not. CNA #1 said she was interviewed in person by the Administrator and the Social Worker on the day of the alleged abuse event.  On 11/4/14 at 11:30 AM, the Administrator was interviewed with the Social Worker, DON, and Clinical Resource Nurse #2 present. The Administrator said he typed CNA #1's summary of events into the investigation report because she was interviewed in his office. When asked if he had CNA #1 write and sign a statement, he stated, "No."	F 226			
{F 246}	483.15(e)(1) REASONABLE ACCOMMODATION	{F 246}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>		
(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	
{F 246} SS=D	<p>Continued From page 12 OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, it was determined the facility did not ensure call light accessibility for 1 of 6 sampled residents (#12). Inability to access her call light as a means of communicating with facility staff placed the resident at risk for unmet needs. Findings included:</p> <p>Resident #12 was admitted to the facility on 8/29/14 with diagnoses of flaccid hemiplegia affecting non-dominant side, cerebrovascular accident (CVA), and muscle weakness.</p> <p>A Significant Change MDS, dated 9/26/14, coded the resident as needing extensive assistance of two people for bed mobility and transfers.</p> <p>On 11/3/14 at 12:05 PM, during the initial tour, Resident #12's door was observed to be closed. The surveyor knocked on the door and was invited in by the resident. Two call lights were plugged into the wall behind and to the left of the resident's bed and the cord of each call light was clipped to itself on the wall. When asked how she alerted staff when in need of assistance, she stated she pushed the button on her call light.</p>	{F 246}	<p>F 246</p> <p>The corrective action for resident #12 was to immediately place the call light within reach of the resident.</p> <p>The facility recognizes that other residents who are dependent for care have a potential to be affected by a similar alleged deficient practice.</p> <p>The measures implemented to ensure that the alleged deficient practice will not reoccur include: DNS and Administrator provided in-service training for staff on 11/7/2014 on the importance of call lights being in place to ensure resident comfort, safety, and compliance. Facility implemented a call-light audit process, which includes daily call light monitoring by IDT seven days per week. Facility DNS/designee will conduct random call light checks to ensure that the IDT monitoring process is effective. In-service, education, and/or counseling will be done with involved staff in the event that call lights are identified to be out of reach for any of our residents.</p> <p>Effectiveness will be monitored daily (7-days per week) for 1 month. If the facility Q.A. &amp; A. committee determines compliance, audits may then be reduced to three times per week for 2 weeks and then periodically thereafter. Monitoring will be done by Administrator and DNS/designee.</p> <p>The results of the monitoring will be presented to the Q.A.&amp;A. Committee to determine effectiveness. All concerns will be addressed with the Administrator. Administrator will ensure compliance.</p> <p>POC date: 11/18/2014</p>		

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

PRINTED: 11/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 11/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>		
(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	
{F 246}	<p>Continued From page 13</p> <p>The resident looked around on her blanket and bed and stated, "I don't know where it is, they [staff] usually clip it to my blanket."</p> <p>On 11/3/14 at 12:20 PM, LN #4 accompanied the surveyor to the resident's room and confirmed the call lights were clipped to the cord on the wall and not within the resident's reach. When asked where the call light should be placed the LN stated it should be where the resident can reach it. The LN removed the clipped call light from the wall and attached it to the resident's blanket.</p> <p>On 11/5/14 at 9:55 AM, the DNS was informed of the identified concern. No additional information was provided.</p>	{F 246}			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 11/05/2014
--	---	---	---

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) COMPLETE DATE
{C 000}	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the onsite follow up and complaint survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Linda Kelly, RN	{C 000}		
C 170	02.100,12,c,ii Factual Description of Incident/Accident  ii. A factual description of the incident or accident; This Rule is not met as evidenced by: Please refer to F226 as it relates to completed investigations.	C 170	C 170 - Refer to F 226	
C 173	02.100,12,d Immediate Notification of Physician of Injury  d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Refer to F157 as it related to physician notification of a subtherapeutic Dilantin level.	C 173	C 173 - Refer to F 157	
{C 393}	02.120,04,b Staff Calling System at Each Bed/Room  b. A staff calling system shall be installed at each patient/resident bed and in each patient/resident toilet, bath and shower room. The staff call in the toilet, bath or shower room	{C 393}	C 393 - Refer to F 246	

RECEIVED  
NOV 11 2014  
FACILITY COMPLIANCE

Bureau of Facility Standards

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

TITLE

(X6) DATE

*[Signature]*

ADMINISTRATOR

11/28/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001240</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 11/05/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>
--	---

(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) COMPLETE DATE
{C 393}	Continued From page 1  shall be an emergency call. All calls shall register at the staff station and shall actuate a visible signal in the corridor at the patient's/resident's door. The activating mechanism within the patient's/resident's sleeping room shall be so located as to be readily accessible to the patient/resident at all times. This Rule is not met as evidenced by: Please refer to F246 as it relates to call lights.	{C 393}		



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

December 31, 2014

Richard F. Cartney, Administrator  
Monte Vista Hills Healthcare Center  
1071 Renee Avenue  
Pocatello, ID 83201-2508

FILE COPY

Provider #: 135018

Dear Mr. Cartney:

On **November 5, 2014**, a Complaint Investigation survey was conducted at Monte Vista Hills Healthcare Center. Amy Barkley, R.N., Bradley Perry, L.S.W. and Linda Kelly, R.N. conducted the complaint investigation.

This complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure follow-up survey conducted from November 3, 2014 through November 5, 2014.

The following documents were reviewed:

- The identified resident's clinical record;
- The clinical records of six other residents, two regarding falls, three regarding physicians' notification and six regarding following physicians' orders;
- Grievance files for October and November 2014;
- Incident and Accident reports for October and November 2014, including one for the identified resident; and,
- Allegation of Abuse reports for September through November 2014.

Interviews were conducted with the following:

- The identified resident;

- Two Certified Nurse Aides (CNAs);
- Two Licensed Nurses (LNs); and,
- The Director of Nursing Services (DNS).

The identified resident was observed during the survey.

The complaint allegations, findings and conclusions are as follows:

### **Complaint #6723**

#### **ALLEGATION:**

The complainant stated an identified resident fell on October 20, 2014, and received a slash above the eye and hip pain. The Medical Director was in the building and was notified. The DNS was also aware of the incident. The Medical Director saw the resident and said to send the resident out for an X-ray and stitches. The facility did not send the resident out. The wound was steri-stripped and continued to ooze blood.

The resident continues with complaint of pain. The resident does not have family but does have a guardian. The resident's level of activity has declined since the incident. The resident used to be up and about in a wheelchair and is no longer.

#### **FINDINGS:**

An Incident and Accident Report for the identified resident documented the resident fell during a seizure on October 16, 2014. No other Incident and Accident Reports involving falls were found for the identified resident after October 16, 2014.

Per interviews with the identified resident, he/she denied recent or current hip pain and stated, "I'm getting around just fine. Same as I have been for a long time." A faint one-inch long, narrow abrasion was observed to be healed over the resident's left eye.

Per interviews with one of the LNs and both CNAs, there were no changes in the resident's activity level after the October 16<sup>th</sup> fall. Per interview with the other LN, the Medical Director was not in the building and did not see any residents on October 16, 2014.

Per interview with the DNS, he/she assessed the identified resident immediately after the fall and during the seizure activity on October 16, 2014, and notified the resident's physician about the fall and seizure activity.

Richard F. Cartney, Administrator  
December 31, 2014  
Page 3 of 3

The identified resident's clinical record contained documentation that the identified resident's cognitive level was intact, the resident's activity level did not change after the October 16<sup>th</sup> fall, the attending physician was notified of the October 16<sup>th</sup> fall and seizures, the physician ordered steri-strips to a laceration above the left eye and to be updated if the resident's condition did not improve after the seizures. In addition, the clinical record contained documentation that the resident's Dilantin (anti-seizure medication) level was subtherapeutic on October 7, 2014, nine days before the seizures and fall. However, there was no documented evidence the resident's physician was notified of the subtherapeutic Dilantin level until after the fall and seizures on October 16, 2014.

Based on the records reviewed and residents' and staff's interviews, it was determined the allegation could not be substantiated. However, the facility was cited at F157 for failure to ensure the resident's physician was notified of the subtherapeutic Dilantin level.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

As none of the complaint's allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a stylized "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj



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

December 11, 2014

Richard F. Cartney, Administrator  
Monte Vista Hills Healthcare Center  
1071 Renee Avenue  
Pocatello, ID 83201-2508

FILE COPY

Provider #: 135018

Dear Mr. Cartney:

On **November 5, 2014**, a Complaint Investigation survey was conducted at Monte Vista Hills Healthcare Center. Amy Barkley, R.N., Bradley Perry, L.S.W. and Linda Kelly, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure follow-up revisit conducted from November 3, 2014 through November 5, 2014.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Two other residents' records were reviewed for abuse allegations;
- The facility's grievance files for October and November 2014;
- Resident Council minutes for October and November 2014;
- The facility's Incident and Accident reports for October and November 2014;
- The facility's staff working schedules from October 17 to November 3, 2014; and,
- The facility's Allegation of Abuse reports from September through November 2014.

The following interviews were completed:

- Three CNAs were interviewed regarding abuse policies and protocols; and,
- The Director of Nursing, the Administrator and the Social Worker were interviewed regarding abuse allegations and investigations.

Richard F. Cartney, Administrator  
December 11, 2014  
Page 2 of 3

The complaint allegations, findings and conclusions are as follows:

**Complaint #6726**

**ALLEGATION #1:**

The complainant stated that on October 24, 2014, an identified resident was abused, when an identified CNA threw a soiled adult brief at the resident, striking the resident in the face two times.

**FINDINGS #1:**

An investigation report for the identified resident was reviewed, and it documented conflicting reports of the two CNAs involved in the resident's care.

The accused CNA was interviewed and he/she stated the alleged incident did not happen as reported. The Administrator was interviewed, and he stated due to the CNA statements, an interview with the resident and other potential witnesses the allegation of abuse could not be substantiated by the facility.

Based on the records reviewed and staff interviews, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The complainant stated that an accused CNA was never suspended during an alleged abuse investigation and was allowed to work his/her next shift.

**FINDINGS #2:**

An investigation report for the identified resident was reviewed, and it documented the facility initiated an investigation on October 24, 2014, at 9:00 a.m., and it was concluded the same day at 7:00 p.m. The CNA staffing records documented the accused CNA left work at 7:00 a.m. on October 24, 2014, and did not work again until 7:00 p.m. on October 25, 2014.

The Administrator was interviewed and he stated the accused CNA did not work while the investigation was in progress.

Richard F. Cartney, Administrator  
December 11, 2014  
Page 3 of 3

Based on the records reviewed and staff interviews, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The complainant stated he/she was concerned for the safety of the identified resident and all other residents in the facility.

**FINDINGS #3:**

The identified resident's and two other residents' abuse investigation reports were reviewed, and it was determined the facility did not conduct a thorough investigations and failed to report the alleged abuse cases to the state survey agency.

The allegation was substantiated, and the facility was cited at F226.

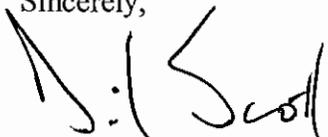
**CONCLUSIONS:**

Substantiated. Federal and State related to the allegation were cited on the follow-up revisit survey report.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large initial "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj