



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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February 1, 2017

Clayton South, Administrator
Monte Vista Hills Healthcare Center
1071 Renee Avenue
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. South:

On **January 26, 2017**, a survey was conducted at Monte Vista Hills Healthcare Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 13, 2017**. Failure to submit an acceptable PoC by **February 13, 2017**, may result in the imposition of penalties by **March 8, 2017**.

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; and
- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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 **March 2, 2017 (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 **April 26, 2017**. A change in the seriousness of the deficiencies on **March 12, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 26, 2017** includes the following:

Denial of payment for new admissions effective **April 26, 2017**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **July 25, 2017**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., 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. 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 **April 26, 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:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **February 13, 2017**. If your request for informal dispute resolution is received after **February 13, 2017**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style.

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj

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

PRINTED: 02/21/2017
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 01/26/2017
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 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility January 23, 2017 through January 26, 2017. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator David Scott, RN Marci Clare, RN Survey Acronyms: CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing Services LN = Licensed Nurse LPM = Liters Per Minute MAR = Medication Administration Record MDS = Minimum Data Set assessment NC = Nasal Cannula O2 = Oxygen OT = Occupational Therapist UTI = Urinary Tract Infection	F 000			
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the	F 315		2/13/17	

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

TITLE

(X6) DATE

Electronically Signed

02/08/2017

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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F 315	<p>Continued From page 1 facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure an order was in place for an indwelling urinary catheter and that catheter care was consistently performed or provided for 1 of 3 residents (#2) reviewed for indwelling catheter use. The failure created the potential for more than minimal harm if Resident #2 developed a UTI due to unnecessary catheter use. Findings include:</p>	F 315	<ol style="list-style-type: none"> 1. Effected resident has had catheter discontinued and removed. 2. Future, new residents have potential to be effected by the alleged deficient practice. Existing, current residents have been reviewed for appropriateness and justification. 3. Nursing staff was re-educated on appropriate catheter use and justification, and on orders that must be present. Upon facility receiving orders for catheter 		

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F 315	<p>Continued From page 2</p> <p>Resident #2 was readmitted to the facility on 1/20/17 with multiple diagnoses, including aspiration pneumonia.</p> <p>Resident #2's 1/14/17 discharge MDS assessment [discharged to hospital] documented the resident did not have an indwelling catheter.</p> <p>Resident #2's 1/19/17 readmission orders did not document an order for a catheter.</p> <p>Resident #2's 1/20/17 LN Initial Admission assessment, documented the resident had an indwelling foley catheter.</p> <p>Resident #2's 1/21/17 through 1/24/17 progress notes, documented the resident had an indwelling catheter.</p> <p>Resident #2 was observed on 1/23/17 at 4:45 pm and on 1/24/17 at 9:00 am, 10:32 am, 12:20 pm, 1:40 pm, and 3:00 pm with an indwelling catheter with clear yellow urine in the catheter tubing.</p> <p>On 1/24/17 at 1:40 pm, LN #1 said Resident #2 was admitted from a local hospital with the catheter.</p> <p>Resident #2's January 2017 Medication Review Report, documented physician orders on 1/24/17 for an indwelling catheter and to provide catheter care every shift. The order did not document the reason for the use of the catheter.</p> <p>Resident #2's January 2017 MAR, documented the resident did not receive catheter care on any shift from 1/20/17 through the day shift of 1/24/17.</p>	F 315	<p>use, the DNS, or designee, will review documentation and justification for appropriateness. Including residents returning to facility from an acute stay.</p> <p>4. DNS, or designee, will audit three (3) new and/or readmitting resident's catheter orders every one (1) week for three (3) months. Results will be reviewed by Q.A.&A. committee monthly until it has been determined by the committee that the system is effective.</p> <p>5. PoC Date <input type="checkbox"/> 2/13/2017</p>		

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F 315	Continued From page 3	F 315			
F 328 SS=D	<p>On 1/25/17 at 10:15 am, the DNS said the catheter order was not put into place until 1/24/17, when the facility found an updated admission order dated 1/19/17. She said the admitting nurse failed to place the catheter order on Resident #2's MAR when the order came to the facility on 1/20/17. The DNS said there was no justification for the catheter and she was working on an order to discontinue the use of the catheter since there was no reason for the catheter to be continued. The DNS said she thought catheter care had been done but could not verify that catheter care had been provided from 1/20/17 through 1/24/17.</p> <p>483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:</p> <p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p> <p>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and</p>	F 328		2/13/17	

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F 328	<p>Continued From page 4 the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents received</p>	F 328	<p>1. Effected resident's O2 was immediately set to correct LPM, per physician's order.</p>		

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F 328	<p>Continued From page 5</p> <p>appropriate respiratory care as ordered by a physician. This was true for 1 of 7 (#7) residents reviewed for oxygen therapy. The deficient practice had the potential for harm if residents received oxygen therapy contrary to physician orders. Findings include:</p> <p>Resident #7 was readmitted to the facility on 8/11/16 with multiple diagnoses including COPD.</p> <p>Resident #7's 8/11/16 Physician's order documented, O2 at 2 LPM to keep saturation levels greater than 90%.</p> <p>Resident #7's 8/19/16 respiratory status care plan documented the resident received oxygen as ordered.</p> <p>Resident #7's January 2017 MAR documented the resident's saturation levels were above 90% for each shift.</p> <p>Resident #7 was observed in his bed on 1/24/17 at 8:50 am, 10:35 am, 12:18 pm, 1:45 pm, and 3:02 pm, and on 1/25/17 at 11:05 am and 1:50 pm, with the room air concentrator set at 3.25 LPM via NC.</p> <p>On 1/24/17 at 8:50 am, Resident #7 said he thought his O2 was set for 3 LPM.</p> <p>On 1/25/17 at 3:20 pm, Resident #7 was observed in his wheelchair in the day room with his O2 companion set at 2 LPM via NC.</p> <p>On 1/26/17 at 8:23 am, the DNS observed Resident #7's O2 companion while the resident was in his wheelchair outside of his room and</p>	F 328	<ol style="list-style-type: none"> 2. Current residents on O2 have potential to be effected and have had LPM flow audited and adjusted for accuracy to physician orders. 3. Facility staff will be in-serviced on correct use of O2 and to follow physician orders and care plan. Treatment Administration Record will be updated to require nurses to review LPM for residents with potential to be effected by this deficient practice. 4. DNS, or designee, will monitor proper use of O2 on three (3) residents three (3) times every one (1) weeks for three (3) months. Results will be reviewed by Q.A.&A. committee monthly until it has been determined by the committee that the system is effective. 5. PoC Date – 2/13/2017 		

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F 328	Continued From page 6 she said the O2 was set at 3 LPM. The surveyor informed the DNS of the other observations and the DNS then checked the order and said the O2 should be set at 2 LPM.	F 328			
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of	F 441		2/13/17	

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F 441	<p>Continued From page 7 infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed standard hand hygiene measures to reduce the risk of infection. This</p>	F 441	<p>1. Employee noted to show the alleged deficient practice was in-serviced immediately on proper protocols.</p> <p>2. Current residents in the facility have</p>		

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F 441	<p>Continued From page 8</p> <p>was true during observation of direct care for 1 of 10 sampled residents (#2). This failure created the potential for the resident to develop infection from cross-contamination. Findings included:</p> <p>The facility's Hand Washing policy documented: "Hand washing is generally considered the most important single procedure for preventing nosocomial infections. Rub hands in circular motion for not less than fifteen (20-30) seconds. Rub fingers between fingers for fifteen (15) seconds."</p> <p>On 1/24/17 at 9:00 am, OT #1 was observed to assist Resident #2 transfer from his bed to his wheelchair. OT #1 positioned Resident #2's wheelchair with bare hands on the handles prior to the transfer and then after the transfer, handled the resident's catheter tubing and privacy bag when she attached them to the resident's wheelchair. OT #1 then adjusted Resident #2's wheelchair foot pedals with both hands, handled the resident's oxygen tubing and detached it from the O2 room air concentrator and connected it to the O2 companion located on the wheelchair. OT #1 then moved the wheelchair forward with her left hand and opened the room door with her right hand. OT #1 then washed her hands for nine seconds in the sink in the room.</p> <p>On 1/24/17 at 2:35 pm, OT #1 said she should have used gloves when handling the resident's catheter tubing and should have washed her hands prior to and after handling the catheter tubing. She also said she should have washed her hands longer than she did.</p>	F 441	<p>the potential to be effected.</p> <p>3. Staff will be re-educated on facility policy and procedure of proper hand-washing.</p> <p>4. DNS, or designee, will monitor through observation the use of proper hand-washing of three (3) staff members every one (1) weeks for three (3) months. Results will be reviewed monthly by Q.A.&A. committee monthly until it has been determined by the committee that the system is effective.</p> <p>5. PoC Date – 2/13/2017</p>		