



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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February 18, 2018

Stephen Farnsworth, Administrator  
Monte Vista Hills Healthcare Center  
1071 Renee Avenue  
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Farnsworth:

On **February 8, 2018**, 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.

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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 **March 2, 2018**. Failure to submit an acceptable PoC by **March 2, 2018**, may result in the imposition of penalties by **March 8, 2018**.

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 15, 2018 (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 **May 9, 2018**. A change in the seriousness of the deficiencies on **March 25, 2018**, may result in a change

Stephen Farnsworth, Administrator  
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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 9, 2018** includes the following:

Denial of payment for new admissions effective **May 9, 2018**. [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 **August 7, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **May 9, 2018** 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:

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<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  
2001-10 IDR Request Form

This request must be received by **March 2, 2018**. If your request for informal dispute resolution is received after **March 2, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief  
Bureau of Facility Standards

dr/dr  
Enclosures

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

PRINTED: 06/04/2018  
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>C</b> <b>02/08/2018</b>
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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>
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(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
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F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint survey conducted at the facility from February 7, 2018 to February 8, 2018.  The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill , RN  Survey Abbreviations: CC = Care Conference CNA = Certified Nurse Assistant DON = Director of Nursing LPN = Licensed Practical Nurse LSW = Licensed Social Worker OM = Operations Manager RN = Registered Nurse SS = Social Services	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)  §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.  §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.  §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		3/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>03/01/2018</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	<p>Continued From page 1 facility that are significant to the resident.</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, ombudsman, and staff interview, it was determined the facility failed to allow residents to make choices to their smoking schedule, when a new smoking policy was implemented and smoking times were reduced. This was true for 2 of 2 (#1 and #2) residents sampled for resident rights. This deficient practice had the potential for psychosocial harm if residents' choices were not honored. Findings include:</p> <p>The Smoking policy, dated September 2007, documented smoking times were 7 AM, 10 AM, 1 PM, 4 PM, and 7 PM.</p> <p>The smoke-free policy, dated September 2017, documented the facility was to be a smoke-free facility and residents who smoked at the time would be accommodated.</p> <p>Resident Council Meeting minutes, dated 8/24/17, documented the facility was to become a smoke-free facility on 9/24/17.</p>	F 561	<p>1-A fifth smoke break has been restored into the grandfathered smoking policy. 2-This affected two residents. No other residents smoke at the facility now or prior to change in policy. 3-The smokes breaks were increased back to five per day. In order to accommodate the rights of all other residents, the fifth smoke break time was changed to 8:00 pm. Updated policy was given to the two residents affected by the smoking policy changes. Smoking times per policy are 7:00 am, 10:30 am, 1:30 pm, 3:30 pm, and 8:00 pm. Staff was in-serviced on smoking policy and related smoking times. 4-The smoke breaks will be audited for two weeks and monthly for 3 months to ensure that they are occurring in accordance with the new policy. The audits will be reviewed in the QA monthly meeting or until it has been deemed the systems are sufficient.</p>		

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F 561	<p>Continued From page 2</p> <p>The current Smoking policy, dated October 2017, documented smoking times were 7 AM, 11 AM, 3:30 PM, and 9 PM. It documented an acknowledgment, by signature of the resident or responsible party, to agree to and abide by the policy.</p> <p>1. Resident #1 was readmitted to the facility on 12/15/16 who was diagnosed with nicotine dependence on 6/8/17.</p> <p>Resident #1's smoking care plan documented an intervention, dated 12/15/16, to explain the smoking policy to the resident.</p> <p>Social Service notes (SS) and Care Conference (CC) notes documented the following:            *9/12/17-SS-The resident was informed on 8/24/17 that the facility was going smoke-free.            *9/12/17-CC-The resident did not want to stop smoking and had expressed concerns of the facility going "smoke-free." The administrator had still been in the process determining regulatory requirements for a smoke-free facility and that the resident should "prepare herself to go smoke-free" as of the date the facility had set.            *10/5/17-CC-The ombudsman was present for the care conference and the resident was "displeased" with the recent changes to the facility's smoking policy. The facility had been working on updating the policy to include the resident be grandfathered (allowed to smoke after the change) and not affected by the change.            *10/10/17-SS-The resident "was provided with the smoking policy on this date" and the resident refused to sign the policy until she could review it with a family member.            *11/2/17-SS-The resident met with the</p>	F 561			

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F 561	<p>Continued From page 3</p> <p>ombudsman, the LSW, RN #1, the resident's family member, and the Operations Manager (OM). The resident continued to want more than the facility would accommodate.</p> <p>*11/8/17-CC-The resident met with the ombudsman, the resident's family member, and the IDT (Interdisciplinary Team). The resident felt that the current smoking times were not adequate and wanted additional times. The resident was informed that "at this time facility administration does feel that the current smoking times and policies do allow for adequate accommodation [sic] for smoking,"</p> <p>Resident #1's unsigned, current Smoking Policy, dated October 2017, documented the resident had refused to sign the policy when presented to her on 10/10/17.</p> <p>On 2/7/18 at 3:20 PM, a facility sign was on a wall next to the exit door by the smoking area. The sign documented smoking times were 7 AM, 11 AM, 3:30 PM, and 9 PM.</p> <p>On 2/7/18 at 3:45 PM and 2/8/18 at 11 AM, Residents #1 and #2 were observed smoking outside, in the designated smoking area, with Therapy Aide #1 and/or the LSW.</p> <p>On 2/8/18 at 8:45 AM, the local ombudsman said she met with Resident #1 and facility staff on 10/5/17, 11/2/17, and 11/8/17 regarding the smoking policy changes and was there to advocate for the resident's rights because smoking was important to the resident. She said a document provided to her by a resident listed facility smoking times prior to the new policy of 7 AM, 10 AM, 1 PM, 4 PM, 7 PM, and 10:30 PM.</p>	F 561			

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F 561	<p>Continued From page 4</p> <p>She said Resident #1 wanted #2 more smoking times than the facility Administrator or the OM wanted to allow.</p> <p>On 2/8/18 at 10:05 AM, Resident #1 said the LSW verbally told her in August or September of 2017 that the administration had decided that the facility was going to become a smoke-free facility. She said she did not want to quit smoking and said she was not informed of her rights of being grandfathered to smoke until the first meeting with the ombudsman in October 2017. She said she was angry that she had to go through the "hassle" of having the ombudsman step in to help resolve issues and help protect her rights. She said the smoking times were also started prior to receiving the new smoking policy, and that she refused to sign the policy because she did not agree with the reduction in times. She said she wanted the 2 smoking times back, that were lost when the new policy change was put into place. She felt like there were "plenty of staff " to accommodate the addition of those smoking times back.</p> <p>2. Resident #2 was admitted on 2/20/16 and readmitted on 12/28/17 with multiple diagnoses including cerebral infarction and anxiety disorder.</p> <p>Resident #2's care plan, created on 2/22/16, documented the following:</p> <ul style="list-style-type: none"> <li>* Explain the smoking policy.</li> <li>* Monitor to assess compliance with the facility's smoking policy and the resident's individual plan.</li> <li>* "Keep routine consistent and try to provide consistent care givers as much as possible to decrease confusion," was initiated on 2/29/16.</li> <li>* Provide "as many situations as possible" where</li> </ul>	F 561			

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F 561	<p>Continued From page 5</p> <p>the resident has control over her environment and care delivery, was initiated on 2/29/16. * "Assist with a program of activities that is meaningful and of interest" was initiated on 2/29/16.</p> <p>Resident #2's Order Summary Report, dated 2/8/18 at 11:24 AM, documented the following: * Resident #2 could participate in recreational activities of choice, and was ordered on 2/19/16.</p> <p>Resident #2's Smoking Policy, revised 10/2017, documented she signed the policy on 10/10/17.</p> <p>On 2/8/18 at 10:05 AM, Resident #2 said when she first arrived at the facility, smoke times were every 2 hours starting at 7:00 AM. The smoke times were changed to every 3 hours about 6 months later. The social worker gave the resident a piece of paper notifying her of the changes, she thought the new change occurred on the same day she received the written notification. The resident said the current smoking schedule was 4 times a day. Resident #2 said the facility tried to take away the smoking times until the ombudsman was contacted, then she was "grandfathered." The resident said the smoking area was moved across the parking lot and current smoking times were 7:00 AM, 11:00 AM, 3:30 PM, and 9:00 PM. The resident said and that she would be pleased if two additional smoke times were added to the current schedule. Resident #2 said she really missed the 1:00 PM and 7:00 PM smoke times, that she had talked to the social worker and was told "there's nothing we can do" and "we're working on it."</p> <p>On 2/8/18 at 11:15 AM, Therapy Aide #1 said the</p>	F 561		

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F 561	<p>Continued From page 6</p> <p>residents smoked 6 times a day, prior to the new policy change.</p> <p>On 2/8/18 at 11:18 AM, LPN #1 said residents smoked every 3 hours during the day and evening hours, prior to the new policy change.</p> <p>On 2/8/18 at 11:30 AM, CNA #1 said residents smoked every 2 hours, on the odd hours, during the day, prior to the new policy change.</p> <p>On 2/8/18 at 11:35 AM, Activity Aide #1 said residents smoked every 2 to 3 hours, prior to the new policy change.</p> <p>On 2/8/18 at 1:30 PM, RN #1 said Residents #1 and #2 wanted more smoking times and the facility administration did not want to provide more than the 4 times listed on the new policy.</p> <p>On 2/8/18 at 2:00 PM, the LSW said the Administrator (who no longer worked at the facility) asked her to inform those who smoked that the facility was to become smoke-free on 9/24/17 and said she informed the Resident Council on 8/24/17. She said Residents #1 and #2 were not in attendance at that Council meeting, so she verbally informed them on that day. She said she believed the new smoking policy, including the new times, had begun the week of September 24th. She said she presented the new smoking policy to Residents #1 and #2 on 10/10/17. She said that prior to the policy change, residents smoked 5 times a day.</p> <p>On 2/8/18 at 3:10 PM, the DON said that prior to the policy change, residents smoked 5 times a day. She said the facility had tried to</p>	F 561			

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F 561	Continued From page 7 accommodate residents who smoked, but had to balance the needs of the other residents at the same time.	F 561			
F 572 SS=D	<p>On 2/8/18 at 3:30 PM, the OM said he had supported the new facility smoking policy and Resident #1 wanted more smoking times than what was on the policy.</p> <p>Notice of Rights and Rules CFR(s): 483.10(g)(1)(16)</p> <p>§483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>§483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on record review, resident, ombudsman, and staff interview, it was determined the facility failed to inform residents of their rights prior to the implementation of a new smoking policy. This</p>	F 572	<p>1-Administration staff have been educated on the 30 day written notice for any changes to policy. 2-All residents have the potential to be</p>	3/1/18	

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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 572	<p>Continued From page 8</p> <p>was true for 2 of 2 (#1 and #2) residents sampled for resident rights. This deficient practice had the potential for psychosocial harm if residents were not informed of their rights. Findings include:</p> <p>The Smoking policy, dated September 2007, documented smoking times were 7 AM, 10 AM, 1 PM, 4 PM, and 7 PM.</p> <p>The smoke-free policy, dated September 2017, documented the facility was to be a smoke-free facility and those who smoked at the time were to be "grand-fathered in."</p> <p>Resident Council Meeting minutes, dated 8/24/17, documented the facility was to become a smoke-free facility on 9/24/17.</p> <p>The current Smoking policy, dated October 2017, documented smoking times were 7 AM, 11 AM, 3:30 PM, and 9 PM. It documented an acknowledgment, by signature of the resident or responsible party, to agree to and abide by the policy.</p> <p>1. Resident #1 was readmitted to the facility on 12/15/16 and received a diagnosis of nicotine dependence on 6/8/17.</p> <p>Resident #1's smoking care plan documented an intervention, dated 12/15/16, to explain the smoking policy to the resident.</p> <p>Social Service notes (SS) and Care Conference (CC) notes documented the following: *9/12/17-SS-The resident was informed on 8/24/17 that the facility was going smoke-free, *9/12/17-CC-The resident did not want to stop</p>	F 572	<p>affected.</p> <p>3-No policy will change from this point forward without giving written notice to all residents at least 30 days prior to implementation. CMS resident rights were reviewed in QAPI on 2/19/18.</p> <p>4-Any future policy changes will be reviewed in the monthly QA meeting to ensure notice has been provided before implementation.</p>		

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

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F 572	<p>Continued From page 9</p> <p>smoking and had expressed concerns of the facility going "smoke-free." The administrator had still been in the process determining regulatory requirements for a smoke-free facility and that the resident should "prepare herself to go smoke-free" as of the date the facility had set.</p> <p>*10/5/17-CC-The ombudsman was present for the care conference and the resident was "displeased" with the recent changes to the facility's smoking policy. The facility had been working on updating the policy to include the resident be grandfathered in to smoke,</p> <p>*10/10/17-SS-The resident "was provided with the smoking policy on this date" and the resident refused to sign the policy until she could review it with a family member.</p> <p>Resident #1's unsigned, current Smoking Policy, dated October 2017, documented the resident had refused to sign the policy, when presented to her on 10/10/17.</p> <p>On 2/8/18 at 8:45 AM, the local ombudsman said she first met with Resident #1 and facility staff on 10/5/17 regarding the smoking policy changes and was there to advocate for the resident's rights. She said at that meeting the resident was verbally informed by facility staff that the resident would be "grandfathered in" and would be allowed to continue to smoke. She said the new smoking policy had been implemented the end of September 2017.</p> <p>On 2/8/18 at 10:05 AM, Resident #1 said the LSW verbally told her in August or September of 2017 that the administration had decided that the facility was going to become a smoke-free facility. She said she did not want to quit smoking</p>	F 572			

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F 572	<p>Continued From page 10</p> <p>and said she was not informed of her rights of being grandfathered in to smoke until the first meeting with the ombudsman in October 2017. She said she was angry that she had to go through the "hassle" of having the ombudsman step in to help resolve issues and help protect her rights. She said the smoking times were also started prior to receiving the new smoking policy, and that she refused to sign the policy because she did not agree with the reduction in times.</p> <p>2. Resident #2 was admitted on 2/20/16 and readmitted on 12/28/17 with multiple diagnoses including cerebral infarction and anxiety disorder.</p> <p>Resident #2's care plan, created on 2/22/16, documented the following:</p> <ul style="list-style-type: none"> <li>* Explain the smoking policy.</li> <li>* Monitor to assess compliance with the facility's smoking policy and the resident's individual plan.</li> <li>* "Keep routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion," was initiated on 2/29/16.</li> </ul> <p>Resident #2's Smoking Policy, revised 10/2017, documented she signed the policy on 10/10/17.</p> <p>On 2/8/18 at 10:05 AM, Resident #2 said when she first arrived at the facility, smoke times were every 2 hours starting at 7:00 AM. The smoke times were changed to every 3 hours about 6 months later. The social worker gave the resident a piece of paper notifying her of the change, she thought the new change occurred on the same</p>	F 572			

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F 572	<p>Continued From page 11</p> <p>day she received the written notification. The resident said the current smoking schedule was 4 times a day. Resident #2 said the facility tried to take away the smoking times until the ombudsman was contacted, then she was "grandfathered." The resident said she was verbally told by facility staff that the facility was going to go non-smoking the next month.</p> <p>On 2/8/18 at 2:00 PM, the LSW said the Administrator (who no longer worked at the facility) asked her to inform those who smoked that the facility was to become smoke-free on 9/24/17 and said she informed the Resident Council on 8/24/17. She said Residents #1 and #2 were not in attendance at that Council meeting, so she verbally informed them on that day. The LSW said at the time of the verbal notification, the facility was looking into the regulations regarding grandfathering in those who smoked. She said she believed the new smoking policy, including the new times, had begun the week of September 24th. She said she presented the new smoking policy to Residents #1 and #2 on 10/10/17.</p> <p>On 2/8/18 at 3:10 PM, the DON said the facility did not provide residents who smoked with the new smoking policy until after it had been implemented.</p>	F 572			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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January 14, 2019

Andrew Sievers, Administrator  
Monte Vista Hills Healthcare Center  
1071 Renee Avenue  
Pocatello, ID 83201-2508

Provider #: 135018

Dear Mr. Sievers:

On **February 7, 2018** through **February 8, 2018**, an unannounced on-site complaint survey was conducted at Monte Vista Hills Healthcare Center. The facility smoking area was observed throughout the survey. Residents and staff were observed during smoking times throughout the survey. Posted smoking signs were observed throughout the survey.

The clinical records of the identified resident and one other resident were reviewed for Resident Rights concerns. The facility's Grievance file was reviewed, as well as Resident Council meeting minutes, smoking policies, and admission agreements.

Residents who smoked, the ombudsman, and several staff were interviewed regarding Resident Rights concerns. The Social Worker, Maintenance Supervisor, Director of Nursing, Operations Manager, and the Administrator were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007694**

ALLEGATION #1:

The Reporting Party said an identified resident was not provided his/her smoking rights prior to the facility implementing a new smoking policy.

FINDINGS #1:

Based on record review, resident, ombudsman, and staff interview, it was determined the allegation was substantiated and the facility was cited at F572.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident's choices regarding smoking times were not being accommodated.

FINDINGS #2:

Based on record review, resident, ombudsman, and staff interview, it was determined the allegation was substantiated and the facility was cited at F561.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility's smoking area was moved and the new area lacked protection from the wind.

FINDINGS #3:

The facility smoking area was observed, on a fairly windy day, and the new smoking area was observed to offer more protection from the wind, than the old area, due to an outbuilding next to the smoking area that provided protection from the wind.

The Resident Council minutes and the facility Grievance file did not document a concern regarding the lack of wind protection in the smoking area.

The Maintenance Supervisor said the outbuilding next to the smoking area provided protection from the wind.

Andrew Sievers, Administrator  
January 14, 2019  
Page 3 of 3

Based on observation, record review, and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj