



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 18, 2018

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

Provider #: 135018

Dear Mr. Sievers:

On **May 4, 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.

Andrew Sievers, Administrator
May 18, 2018
Page 2 of 4

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 **May 28, 2018**. Failure to submit an acceptable PoC by **May 28, 2018**, may result in the imposition of penalties by **June 22, 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 **June 8, 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 **August 2, 2018**. A change in the seriousness of the deficiencies on **June 18, 2018**, may result in a change in the remedy.

Andrew Sievers, Administrator
May 18, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **August 2, 2018** includes the following:

Denial of payment for new admissions effective **August 2, 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 **October 31, 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 **August 2, 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:

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

Andrew Sievers, Administrator
May 18, 2018
Page 4 of 4

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

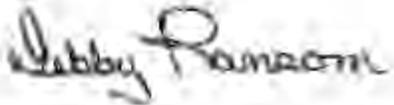
- BFS Letters (06/30/11)

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

This request must be received by **May 28, 2018**. If your request for informal dispute resolution is received after **May 28, 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/lj
Enclosures

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

PRINTED: 06/05/2018
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 05/04/2018
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 and complaint survey conducted April 30, 2018 to May 4, 2018. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Bradley Perry, LSW Teri Hobson, RN Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing Services MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram OT = Occupational Therapy/Therapist PEG = Percutaneous Endoscopic Gastrostomy PRN = As Needed PT = Physical Therapy/Therapist PTA - Physical Therapy Assistant RN = Registered Nurse RNP = Restorative Nursing Program ROM = Range of Motion	F 000			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583		5/25/18	

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

TITLE

(X6) DATE

Electronically Signed

05/25/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135018	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2018
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 583	<p>Continued From page 1 private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a resident's privacy was maintained during personal care. This true for 1 of 6 residents (#30) observed during the provision of personal care. The failure created the potential for Resident #30 to be embarrassed if her body was exposed to others unnecessarily. Findings include: On 05/1/18 at 9:52 AM, CNA #1 and the DNS were observed as they transferred Resident #30 to bed, pulled her pants down, checked her incontinence brief, pulled her pants up, then</p>	F 583	<p>1-Facility ensured that all window coverings in resident rooms were properly functioning. Social Worker educated the employees involved regarding resident privacy on 5/2/18. 2-All residents that receive personal cares in their rooms have the potential to be affected by this practice. 3-Plant operations to confirm all resident room window coverings are adequate to preserve resident's privacy. Plant operations will complete audit by 5/23/18. Social Services provided facility staff</p>		

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 05/04/2018
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 583	Continued From page 2 repositioned her to her side. During this time, the window blind was raised eight inches. The grass lawn was visible from the resident's window. On 05/2/18 at 11:21 AM, CNA #2 was observed as she completed incontinence care for Resident #30, pulled up the resident's pants, then placed a mechanical lift sling under the resident. During this time, the window blind was raised eight inches. The recently mowed lawn was visible from the resident's window. When asked about the raised window blind, CNA #2 said she forgot to lower the blind when she changed the resident's incontinence brief. On 5/3/18 at 6:30 PM the DNS said the window blind should have been lowered when Resident #30 received personal care in her room.	F 583	education in the areas of resident privacy performed on 5/8/18 and 5/16/2018. Audits to begin on 5/24/18. 4-Social Services or designee will audit that personal cares are performed in privacy and with dignity five times per week for three weeks and then three times per week for three weeks and then once per week for one month and report findings to QAPI committee.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		5/25/18	

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 05/04/2018
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 657	<p>Continued From page 3</p> <p>and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care plans were revised as residents' needs changed. This was true for 2 of 14 sample residents (#8 and #16) whose care plans were reviewed. The failure created the potential for harm when Resident #16's care plan was not revised to include upper extremity ROM and cone splints, and when Resident #8's care plan was not revised to include non-pharmacological interventions for managing the resident's anxiety. Findings include:</p> <p>1. Resident #16 was admitted to the facility on 8/11/17 with multiple diagnoses, including traumatic brain injury and quadriplegia.</p> <p>The admission MDS assessment, dated 8/22/17, documented Resident #16 had severe cognitive impairment, required extensive to total assistance of 1 to 2 people for all ADLs, and had 3 days of OT.</p> <p>The 11/21/17 quarterly MDS assessment differed from the 8/22/17 MDS in that it documented OT ended 10/18/17 and Resident #16 had 3 days of</p>	F 657	<p>1-Resident #16 Care Plan was updated to reflect current cares on 5/2/18. Resident #8 Care Plan was update to reflect current cares on 5/22/18</p> <p>2-All residents have the potential to be affected by this practice.</p> <p>3-Facility has implemented a weekly IDT care plan review process to ensure that resident care plans reflect current care needs. Nursing staff were educated on facility care plan process and updates of care on 5/14/18.</p> <p>4-DNS or designee will audit accuracy of weekly IDT care plan meeting one time per week for two months. DNS or designee to audit five selected resident care plans for accuracy each week ongoing. Audits begin 5/24/18 and findings reported to QAPI committee.</p>		

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

PRINTED: 06/05/2018
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 05/04/2018
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 657	<p>Continued From page 4 a Restorative Nursing Program (RNP).</p> <p>The 2/20/18 quarterly MDS assessment, differed from the 11/21/17 MDS in that it documented the resident had 1 day of a Restorative Nursing Program.</p> <p>A 10/18/17 OT Discharge Summary documented that at baseline (8/16/17), Resident #16 would not allow hand splints to be placed without biting and hitting; by 10/11/17 that 75% of CNAs had been trained to place cone splints in the resident's hands; and by discharge (10/18/17), CNAs had been trained on cone splint placement. The OT Discharge Summary recommendations included, "Continue wearing cone splints to prevent contracture...Restorative Program Established/Trained..."</p> <p>Resident #16's 11/20/17 PT Discharge Summary documented, "RNA trained on ROM techniques..."</p> <p>The 8/12/17 ADL care plan was revised on 11/13/17 to include an intervention for nursing rehabilitation 3 days per week for passive ROM to the hips and lower extremities.</p> <p>Resident #16's care plan did not include an intervention for an RNP for the upper extremities and cone splints to the hands as recommended by OT on 10/18/17.</p> <p>On 5/2/18 at 3:45 PM, the MDS nurse said she managed the RNP and that Resident #16's restorative nursing involved ROM to the hips and lower extremities.</p>	F 657			

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 05/04/2018
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 657	<p>Continued From page 5</p> <p>On 5/3/18 at 1:44 PM, the MDS nurse said the OT recommendations for a restorative program and continuation of the cone splints should have been included in Resident #16's care plan but it was over looked.</p> <p>2. Resident #8 was readmitted to the facility on 11/9/15 with multiple diagnoses, including respiratory failure.</p> <p>The care plan which addressed psychotropic medications and anxiety, dated 11/10/15 and revised on 1/31/18, did not direct staff on what to do when the resident became anxious.</p> <p>A hospice physician's order, dated 1/26/18, documented an order for Lorazepam .5 mg every 4 hours PRN for anxiety.</p> <p>Resident #8's MAR from 1/26/18 through 5/2/18, documented the Lorazepam was administered one time on 3/8/18 and it was effective</p> <p>On 4/30/18 at 5:59 PM, and on 5/1/18 at 11:17 AM, 12:56 PM, and 4:58 PM, Resident #8 was observed in her wheelchair either in the dining room or in the hallway and did not appear to display signs or symptoms of anxiety.</p> <p>On 5/3/18 at 8:17 AM, LPN #2 said Resident #8 was occasionally anxious, but staff would talk with her, redirect her with food, or provide an activity.</p> <p>On 5/3/18 at 8:31 AM, the DNS said the care plan which addressed psychotropic medications and anxiety, did not direct staff to attempt non-pharmacological interventions. She said</p>	F 657			

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 05/04/2018
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 657	Continued From page 6 when the resident became anxious she would personally hold Resident #8's hand and the resident would usually calm down.	F 657			
F 684 SS=D	On 5/3/18 at 9:19 AM, CNA #4 said Resident #8 usually did not get anxious. She said when the resident became anxious she would talk with her and she would calm down. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record and policy review, it was determined the facility failed to ensure medications were administered in accordance with professional standards of practice. This was true for 4 of 26 medications administered during medication pass observations. This deficient practice directly impacted 2 of 6 residents (#5 and #16) whose medication administration was observed. Failure to check the medication pharmacy label against the physician's orders and/or MAR resulted in Resident #5's powder laxative being mixed in less fluid than ordered and created the potential for Resident #16's medications to be administered by the wrong route. Findings include:	F 684	1-Resident #5's MAR/orders were updated to reflect administration directions per OTC recommendations. MD's confirm order changes for laxative medication on 5/11/18. On 5/2/18 pharmacist consultant re-labeled all mislabeled medications to reflect administration by PEG tube for Resident #16. 2-All residents have the potential to be affected by this practice. 3-Nursing staff was educated on proper medication administration per facility policy and procedure on 5/14/18. All laxative orders were updated to reflect OTC recommendations on 5/12/18.	5/25/18	

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 05/04/2018
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 684	Continued From page 7 1. On 5/2/18 at 9:15 AM, RN #1 was observed as she poured, then administered 7 medications for Resident #5, including polyethylene glycol (laxative) 17 gm in about 3 1/2 ounces of water. The resident took 3 sips of the polyethylene glycol water then refused the rest of the medication. Immediately after the administration, RN #1 was asked to reread the pharmacy label on Resident #5's polyethylene glycol medication. After rereading the polyethylene glycol pharmacy label, the RN compared the label to the May 2018 MAR instructions and the 9/21/17 physician's order for the medication. RN #1 said the medication was ordered to be mixed in 6 to 8 ounces of fluid. 2. On 5/2/18 at 1:30 PM, RN #1 was observed as she poured, then administered 4 medications via Resident #16's PEG tube. The medications included the muscle relaxant, cyclobenzaprine; the gastrointestinal stimulant, metoclopramide; and the anticonvulsant, phenytoin. The pharmacy labels for these 3 medications directed administration "by mouth" rather than per PEG tube. Immediately after the administration, RN #1 was asked to reread the pharmacy labels on Resident #16's cyclobenzaprine, metoclopramide, and phenytoin medications. The RN reread the pharmacy labels then compared the labels to the physician orders and the May 2018 MAR instructions for the 3 medications. RN #1 then said the 3 medications were ordered to be administered via PEG tube and the pharmacy	F 684	Larger 9 oz. cups were placed on med carts on 5/2/18. 4-DNS/designee performed med cart audit to ensure medication label accuracy on 5/7/18. DNS or designee to audit new medication cards and medication orders arriving five times per week for four weeks and then three times per week for four weeks. Report findings to QAPI committee. Audits to begin on 5/24/18.		

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

PRINTED: 06/05/2018
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 05/04/2018
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 684	Continued From page 8 label directions for administration by mouth were wrong for all 3 of the medications. On 5/2/18 at 4:30 PM, the DNS provided the facility's 2007 Medication Pass Observation policy which documented, "The medication label must be checked against the medication sheet to ensure the proper medication and dose is administered..." and "The Six Rights of Medication Pass...Right Drug...Medication label should match the medication order...Right Route...Dosage form needs to be consistent with the physician order..."	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	F 688	1-Resident #16's care plan was updated	5/25/18	

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 05/04/2018
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 688	<p>Continued From page 9</p> <p>review, it was determined the facility failed to ensure residents received treatment and services to prevent decrease in ROM. This was true for 1 of 3 residents (#16) reviewed for treatment and services related to ROM. This failure created the potential for harm when a restorative program and cone splints were not implemented or care planned for Resident #16 to prevent deterioration of existing upper extremity ROM limitations. Findings include:</p> <p>Resident #16 was admitted to the facility on 8/11/7 with multiple diagnoses, including traumatic brain injury and quadriplegia.</p> <p>Resident #16's 8/11/17 initial nursing assessment documented bilateral hand contractions and limited ROM in both upper extremities.</p> <p>On 4/30/18 at 3:20 PM, 4:55 PM, and 5:35 PM, Resident #16 was observed with a carrot shaped pad in her left hand. The resident's right fingers were contracted during these observations. Nothing was in the resident's right hand.</p> <p>On 5/1/18 at 4:45 PM and on 5/2/18 at 9:08 AM, 9:33 AM, and 1:30 PM, Resident #16 was observed with nothing in either hand and her fingers on both hands were contracted.</p> <p>On 5/2/18 at 1:30 PM, RN #1 said Resident #16 had 2 carrot shaped pads and that "some" CNAs put them in the resident's hands. The RN said there were no orders or care plan for the carrot pads to be placed in resident's hands.</p> <p>Resident #16's 10/18/17 OT Discharge Summary documented one short-term goal was that the</p>	F 688	<p>on 5/2/18 to reflect the proper use of splints. On 5/21/18 care plan was updated to include care approach to "upper range of motion". MDS modification was completed on 5/21/18 to reflect resident decrease in range of motion.</p> <p>2-All residents receiving range of motion services have the potential to be affected by this practice.</p> <p>3-Facility has implanted a weekly IDT care plan review process to ensure that resident care plans reflect current care needs. Nursing staff were educated on facility care plan process and updates of care on 5/14/18.</p> <p>4-DNS or designee to audit residents transitioning to restorative program for range of motion and splint use once per week for two months. DNS or designee to audit 5 selected resident care plans weekly ongoing. Audits to begin on 5/24/18 and findings reported to QAPI.</p>		

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

PRINTED: 06/05/2018
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 05/04/2018
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 688	Continued From page 10 resident would allow the CNAs to place cone splints without aggressive behavior. This goal was met on 10/18/17 and the summary documented that CNAs were trained on the cone splint placement. OT discharge recommendations included, "Continue wearing cone splints to prevent contracture...Restorative Program Established/Trained..." On 5/2/18 at 3:45 PM, the MDS nurse said she also supervised the RNP. The MDS nurse said Resident #16's care plan included passive ROM to her hips and lower extremities but the care plan did not address the resident's hands or upper extremities. The MDS nurse said there were no orders for pads to be placed in the resident's hands. On 5/3/18 at 1:44 PM, the MDS nurse said she clarified with OT that "cone splints" meant the carrot shaped pads. On 5/3/18 at 7:10 PM, the MDS nurse said the OT recommendation for cone splints had been overlooked and that Resident #16 had not been getting ROM to her upper extremities.	F 688			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		5/25/18	

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 05/04/2018
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 692	<p>Continued From page 11</p> <p>of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were consistently provided with adequate hydration to prevent dehydration. This was true for 1 of 2 residents (#30) reviewed for nutrition/hydration concerns. The failure created the potential for harm if Resident #30 became dehydrated. Findings include:</p> <p>Resident #30 was readmitted to the facility in February 2017 with multiple diagnoses, including dementia, hypokalemia and hyponatremia (low potassium and sodium levels), and acute kidney failure.</p> <p>A 3/27/18 quarterly MDS assessment documented Resident #30 had severe cognitive impairment, she required extensive assistance for eating, and she weighed 135 pounds.</p> <p>Resident #30's nutrition/hydration care plan interventions instructed staff to offer and encourage fluids between meals, initiated 12/28/17; provide extensive to total assistance</p>	F 692	<p>1-CNA was educated on 5/4/18 on facility hydration policy and procedure. Assessment performed by DNS to rule out dehydration on 5/4/18.</p> <p>2-All cognitively impaired residents have the potential to be affected by this practice.</p> <p>3-Orders added for all cognitively impaired residents to monitor fluid intake Q2 hour on 5/4/18. In-services to staff conducted on 5/4/18 and 5/16/18 on the topics of hydration to all residents and specifically to cognitively impaired residents.</p> <p>4-DNS or designee to audit fluid intake order five times per week for four weeks, three times per week for three weeks and once per week for one month. Audits to begin on 5/24/18 and findings reported to QAPI committee.</p>		

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

PRINTED: 06/05/2018
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 05/04/2018
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 692	<p>Continued From page 12</p> <p>with meals as needed, initiated 4/3/18; and assist and encourage nectar thick fluid intake "in order to meet daily requirements," initiated 2/2/17.</p> <p>The resident's active physician's orders documented nectar thick fluids were ordered on 9/6/17.</p> <p>A 3/13/18 Nutrition/Hydration Risk Evaluation documented Resident #30 was at "High Risk."</p> <p>On 4/30/18 at 4:49 PM, Resident #30 was observed awake in bed. There were no fluids for her to drink visible on the resident's side of the room.</p> <p>On 5/1/18 at 9:35 AM, RN #1 said Resident #30 required staff assistance to drink fluids.</p> <p>On 5/1/18 at 9:37 AM, a single handle mug with a lid and a straw was observed on the over bed table near Resident #30's bed. The resident was not in the room at the time.</p> <p>On 5/1/18 at 9:52 AM, CNA #1 and the DNS were observed as they transferred Resident #30 into bed and completed personal care. Following that, CNA #1 moved the over-bed table with the mug on it closer to Resident #30's bed. The DNS and CNA #1 did not offer Resident #30 a drink or ask if she was thirsty before leaving the room.</p> <p>On 5/2/18 at 8:59 AM, 9:50 AM, 10:48 AM, and 11:21 AM, there were no fluids to drink observed on Resident #30's side of the room.</p> <p>On 5/2/18 at 11:21 am, CNA #2 was observed as she completed personal cares for Resident #30.</p>	F 692			

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 05/04/2018
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 692	<p>Continued From page 13</p> <p>CNA #2 did not offer Resident #30 a drink or ask if she was thirsty before leaving the room.</p> <p>On 5/2/18 at 11:35 AM, CNA #2 and CNA #3 were observed as they transferred Resident #30 from her bed to her wheelchair. The CNAs told the resident they were getting her ready for lunch. CNA #2 and CNA #3 did not offer Resident #30 a drink or ask if she was thirsty before they and Resident #30 left the room.</p> <p>On 5/2/18 at 11:45 AM, CNA #2 said she had been Resident #30's caregiver that morning. The CNA said she had not offered Resident #30 a drink since breakfast.</p> <p>On 5/2/18 at 12:30, during the lunch meal service, Resident #30 was observed at a table in the small dining. A nosey cup [a cup with a cut out on the non-drinking side so that they can be tilted without interference by the nose] with thickened milk and a nosey cup with thickened apple juice was on the table in front of Resident #30. At 12:58 PM, CNA #2 was observed as she attempted to feed Resident #30 and assist her to drink the thickened fluids. Resident #30 resisted many bites and sips of fluids. At 1:10 PM, CNA #2 said the resident was not eating or drinking very much and she asked CNA #3 to take over for her.</p> <p>On 5/2/18 at 1:15 PM, the Dietary Manager said both of Resident #30's nosey cups contained 180 milliliters (ml) of fluid each.</p> <p>On 5/2/18 by 1:42 PM, Resident #30 drank 75% of the milk (135 ml) & 65-70% of the juice (120 - 130 ml).</p>	F 692			

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 05/04/2018
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 692	Continued From page 14 According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, 2013, adults in Resident #30's age range should consume 25 ml per kilogram of body weight per day. Using this calculation method, Resident #30 needed a total daily fluid intake of 1534 ml. Fluid intake records, dated 4/3/18 to 5/2/18, documented Resident #30's total fluid intake ranged from 580 ml to 1440 ml per day. The resident's total daily fluid intake was less than 1000 ml on ten of those days and was 1440 ml on one day only. On 5/3/18 4:35 PM, the DNS said she was aware Resident #30 did not drink much fluids on 5/2/18 and that fluids were not consistently being offered to her.	F 692			
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary	F 756		5/25/18	

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 05/04/2018
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 756	<p>Continued From page 15 drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure pharmacy recommendations were followed or addressed by the attending physician. This was true for 1 of 7 residents (#8) reviewed for pharmacy recommendations and had the potential for harm if residents' medications were administered without a clinical rationale. Findings include:</p> <p>1. Resident #8 was readmitted to the facility on 11/9/15 with multiple diagnoses, including respiratory failure.</p>	F 756	<p>1-Resident #8 PRN anxiety medications were discontinued on 5/4/18 due to non-use and lack of clinical rational.</p> <p>2-All resident with prescribed anxiety medications without clinical rational have the potential to be affected by this practice.</p> <p>3-Regulation education was provided to the hospice agency regarding proper anxiety medication use on 5/4/18. All resident who have orders for psychotropic medication were audited on 5/8/18 to ensure use and clinical rational.</p>		

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 05/04/2018
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 756	Continued From page 16 A hospice physician's order, dated 1/26/18, documented an order for Lorazepam .5 mg every 4 hours PRN for anxiety. Resident #8's MAR from 1/26/18 through 5/2/18, documented the Lorazepam was administered one time on 3/8/18 and it was effective. A pharmacy recommendation form, signed by the hospice physician on 4/4/18, documented Resident #8 was on Lorazepam and PRN psychotropic medications were limited to 14 days, unless a clinical rationale was provided. The physician documented to continue the medication and did not document the clinical rationale for its ongoing use. On 5/3/18 at 8:31 AM, the DNS said the hospice physician did not respond to the pharmacist's recommendation to provide a clinical rationale for the Lorazepam.	F 756	4-DNS or designee will audit all new orders for proper psychotropic medication use and clinical rationale five times per week for four weeks, three times per week for three weeks and then weekly ongoing. Audits to begin on 5/24/18 and findings to be reported to QAPI committee.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		5/25/18	

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 05/04/2018
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 758	Continued From page 17 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure there was clinical rationale to continue	F 758	1-On 5/4/18 resident #8 and #46 PRN psychotropic medications were discontinued due to non-use and clinical		

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 05/04/2018
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 758	<p>Continued From page 18</p> <p>PRN psychotropic medications beyond 14 days and non-pharmacological interventions were attempted prior to the use of these medications. This was true for 2 of 7 residents (#8 and #46) reviewed for psychotropic medications. This created the potential for residents to experience adverse reactions from unnecessary anti-anxiety medications. Findings include:</p> <p>1. Resident #8 was readmitted to the facility on 11/9/15 with multiple diagnoses, including respiratory failure.</p> <p>The care plan which addressed psychotropic medications and anxiety, dated 11/10/15 and revised on 1/31/18, did not include non-pharmacological interventions for anxiety.</p> <p>A physician's order, dated 1/24/18, documented the resident was placed on hospice services.</p> <p>A hospice physician's assessment note, date 1/26/18, documented the resident said she was fine and denied any acute concerns and did mention anxiety as a potential concern.</p> <p>A hospice physician's order, dated 1/26/18, documented an order for Lorazepam .5 mg every 4 hours PRN for anxiety.</p> <p>Resident #8's MAR from 1/26/18 through 5/2/18, documented the Lorazepam was administered one time on 3/8/18 and it was effective.</p> <p>The clinical record documented that Resident #8's episodes of anxiety were responsive to non-pharmacological interventions. The prescribing physician failed to provide clinical</p>	F 758	<p>rational.</p> <p>2-All residents with prescribed psychotropic medications without clinical rational have the potential to be affected by this practice.</p> <p>3-Regulation education was provided to the hospice agency regarding proper psychotropic medication use on 5/4/18. On 5/8/18 all residents who have orders for psychotropic medications to ensure use and clinical rational.</p> <p>4-DNS or designee to audit all new orders for proper psychotropic medication use and clinical rational 5 times per week for one month, three times per week for three weeks, and then weekly ongoing. Audits to begin on 5/24/18 and findings reported to QAPI committee.</p>		

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

PRINTED: 06/05/2018
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 05/04/2018
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 758	<p>Continued From page 19</p> <p>rationale and/or indications for a PRN anti-anxiety medication beyond 14 days.</p> <p>On 4/30/18 at 5:59 PM, and 5/1/18 at 11:17 AM, 12:56 PM, and 4:58 PM, Resident #8 was observed in her wheelchair either in the dining room or in the hallway and did not appear to display signs or symptoms of anxiety.</p> <p>On 5/3/18 at 8:17 AM, LPN #2 said Resident #8 was occasionally anxious, but staff would talk with her, redirect her with food, or provide an activity. LPN #2 said she did not think the resident had ever used the Lorazepam order.</p> <p>On 5/3/18 at 8:31 AM, the DNS said there were no non-pharmacological interventions in place prior to starting the Lorazepam. She said she could hold Resident #8's hand if she became anxious and the resident would usually calm down. The DNS said Resident #8's hospice physician ordered the Lorazepam because the resident was placed on hospice and it was part of the hospice comfort care kit. She said the physician did not provide a clinical rationale for the continued use of the medication.</p> <p>2. Resident #46 was admitted to the facility on 10/11/17 with multiple diagnoses, including heart failure and generalized anxiety disorder. Hospice care was in place on admission.</p> <p>Resident #46's active physician's orders documented Lorazepam 0.5 mg every 4 hours PRN for anxiety or restlessness was ordered on 10/11/17.</p> <p>Resident #36's 1/19/18 Psychotropic Medication</p>	F 758			

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

PRINTED: 06/05/2018
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 05/04/2018
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 758	<p>Continued From page 20</p> <p>Review form documented the PRN Lorazepam had not used during the last 30 days and recommended the medication be discontinued for non-use. That same day, the resident's physician disagreed with the recommendation and documented, "Patient is stable, on hospice."</p> <p>A 1/18/18 Note to Attending Physician/Prescriber from the pharmacist documented Resident #46 was prescribed PRN Lorazepam and that PRN psychotropic medications were limited to 14 days, unless a clinical rationale was provided. The note documented the resident had not used Ativan "at least since the beginning of December" and recommended the medication be discontinued. It also documented, "Please consider this, and mark any recommendations below, or provide rationale with the understanding of the need for new orders, or signed review ever 14 day..."</p> <p>On 1/19/18, the physician documented "Disagree" on the 1/18/18 Note to Attending Physician/Prescriber form. The physician did not document a clinical rationale to continue the PRN psychotropic medication.</p> <p>Resident #46's physician disagreed with subsequent recommendations by the pharmacist on 2/13/18, 3/5/18 and 4/2/18 to discontinue Resident #46's PRN Ativan. The physician did not provide a clinical rationale to continue the PRN Ativan.</p> <p>On 5/3/18 at 8:31 AM, the DNS said the hospice physician did not provide a clinical rationale to continue Resident #46's PRN Lorazepam.</p>	F 758			
F 759	Free of Medication Error Rts 5 Prcnt or More	F 759		5/25/18	

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 05/04/2018
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 759 SS=D	<p>Continued From page 21</p> <p>CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors. The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 26 medications (7.69%) which affected 2 of 6 residents (#5 and #45) whose medication passes were observed. The failure created the potential for sub-therapeutic effect when Resident #5's powder laxative was mixed in less fluid than ordered & Resident #45's intravenous (IV) antibiotic was administered late. Findings include:</p> <p>1. On 5/2/18 at 9:15 AM, RN #1 was observed as she poured, then administered 7 oral medications to Resident #5, including polyethylene glycol powder (laxative) 17 grams mixed in approximately 3 1/2 ounces of water. The resident took 3 sips of the polyethylene glycol in water then refused the rest of the medication.</p> <p>Immediately afterward, RN #1 reread Resident #5's polyethylene glycol pharmacy label and May 2018 MAR, then she read the physician order. The pharmacy label, the MAR, and the physician's order all documented the polyethylene glycol was to be mixed in "6 to 8" ounces of fluid. RN #1 said she should have mixed the medication in at least 6 ounces of fluid</p>	F 759	<p>1-Education provided to RN #1, #2 on proper medication administration policy and procedure on 5/4/18.</p> <p>2-All residents have the potential to be affected by this practice.</p> <p>3-a)Nursing staff was education on proper medication administration per facility policy and procedure on 5/14/18. All laxative orders were updated to reflect OTC recommendations. Large 9 Oz. cups were placed on the medication carts on 5/2/18.</p> <p>b)Nursing staff educated on proper IV antibiotic use and storage with expiration dates. DNS audited all refrigerated medication for expiration dates on 5/7/18.</p> <p>4-DNS or designee to conduct medication pass audits for administration of IV antibiotics and laxative medications three times per week for two weeks and weekly for a month. Audits to begin on 5/24/18 and finding to be reviewed in QAPI committee.</p>		

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 05/04/2018
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 759	Continued From page 22 but she had mixed it in less than 4 ounces of fluid. 2. Resident #45 was admitted to the facility on 4/6/18 with multiple diagnoses, including acute osteomyelitis (bone infection) of the left ankle and foot. Resident #45's current physician's orders and May 2018 MAR documented a 4/19/18 order for IV Tygacil (antibiotic) 50 mg 2 times a day until 5/15/18 for left foot osteomyelitis. The MAR documented the Tygacil administration times were 7:00 AM and 7:00 PM. On 5/3/18 at 7:25 AM, RN #2 was observed as she prepared Resident #45's Tygacil 50 mg, for IV administration. RN #2 said the IV medication expired on 5/2/18 at 2:00 PM and there were no other mixed bags of Tygacil available. RN #2 said she would contact the pharmacy and request more Tygacil for the resident as soon as possible. On 5/3/18 at 9:05 AM, RN #1 was observed as she started Resident #45's IV Tygacil 50 mg. The IV antibiotic was more than an hour late when it was started. At that time, RN #2 said the Tygacil was administered late.	F 759			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		5/25/18	

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 05/04/2018
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 761	<p>Continued From page 23 applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure the pharmacy label on 3 of 26 medications matched the physician's orders for 1 of 6 residents (#16) whose medication passes were observed. The failure created the potential for the wrong route of administration for 3 of Resident #16's medications. Findings include:</p> <p>On 5/2/18 at 1:30 PM, RN #1 was observed as she poured, then administered 4 medications via Resident #16's PEG tube. The medications included the muscle relaxant, cyclobenzaprine; the gastrointestinal stimulant, metoclopramide; and the anticonvulsant, phenytoin suspension. The pharmacy label on the cyclobenzaprine, metoclopramide, & phenytoin documented</p>	F 761	<p>1-On 5/2/18 pharmacist consultant re-labeled all mislabeled medications to reflect administration by PEG tube for Resident #16.</p> <p>2-All residents have the potential to be affected by this practice.</p> <p>3-Nursing staff was educated on proper medication administration per facility policy and procedure on 5/14/18. DNS or designee performed medication cart audit of medication label accuracy on 5/7/18.</p> <p>4-DNS or designee to conduct random medication cart audits weekly to ensure proper route of administration is determined on the medication carts. One time per week until determined by QAPI that the system is effective.</p>		

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 05/04/2018
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 761	Continued From page 24 administration "by mouth" rather than by per PEG tube. Immediately afterward, when asked to reread the pharmacy label for the cyclobenzaprine, metoclopramide, and phenytoin, RN #1 said the route of administration on the pharmacy label was wrong on all 3 of the medications. RN #1 then reviewed Resident #16's physician orders which documented administration per PEG tube for all 3 of the previously mentioned medications. The RN said she would contact the pharmacy regarding the medication label errors.	F 761			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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	F 880		5/25/18	

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

PRINTED: 06/05/2018
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 05/04/2018
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 880	<p>Continued From page 25 standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (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 infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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 05/04/2018
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 880	<p>Continued From page 26 infection.</p> <p>§483.80(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, record review, policy review, and staff interview, it was determined the facility failed to ensure: a) Urinary catheter bags and tubing did not rest or drag on the floor. This was true for 2 of 3 (#32 and #46) residents reviewed for urinary catheter use. b) Standard infection control technique and hand hygiene were adhered to during dressing changes. This was true for 1 of 2 (#27) residents whose wound care was observed. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>1. Resident #27 was admitted to facility on 4/29/16, with multiple diagnoses including a cutaneous (skin) abscess of buttock.</p> <p>Resident #27's MDS quarterly assessment dated 5/6/17, documented a non-surgical wound dressing.</p> <p>Resident #27's MDS annual assessment dated 3/16/18, documented normal cognition and the same non-surgical wound dressing.</p> <p>The facility's wound care policy dated 5/2007, did not include the cleaning technique for a wound during dressing changes. It did document hand washing was to be done as outlined in the procedure.</p>	F 880	<p>1-a)Resident #46 catheter bag was hung higher on bed and basin was placed under bag. Resident #32 was educated about risk of infection related to catheter use. LPN #1 and PTA #1 educated on catheter and infection policy and procedure. b)LPN #2 was educated on wound care and hand washing on 5/7/18. Skills check was done with LPN #2 on 5/8/18 by RN. 2-All residents with catheters or wounds have the potential to be affected by this practice. 3-Educated staff on 5/4/18 and 5/16/18 on proper hand washing and prevention of infections related to catheter use per facility policy and procedure. Nurses educated on wound care by American Medical Technologies on 5/14/18 and Portneuf Medical Center wound clinic on 5/31/18. 4-a)DNS or designee will conduct audits of catheter bag and tubing placement five times per week for four weeks, three times per week for four weeks, and then once a week for one month. b)DNS or designee will conduct audits of hand washing and wound care treatments five times per week for four weeks, three times per week for four weeks, and then once a week for one month.</p>		

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 05/04/2018
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 880	Continued From page 27 Resident #27's wound care order dated 2/12/18, documented every day shift, staff was to cleanse the right gluteus wound with normal saline, place a saline dampened gauze pad in the wound bed, apply an absorbent dressing pad, and adhere the dressing with tape . On 5/2/18 at 10:55 AM, LPN #2 removed the dark soiled dressing from Resident #27's right gluteal wound. LPN #2 changed her gloves without washing her hands. LPN #2 cleansed the area around the outside of the wound with a saline moistened 4x4 inch gauze pad, then wiped the inside wound bed with the same moistened gauze pad. On 05/2/18 at 10:59 AM, LPN #2 stated she contaminated the wound during the change. On 05/3/18 at 09:02 AM, the MDS nurse stated she expected staff to wash their hands prior to donning gloves. She also stated that staff was expected to wash their hands between dirty and clean glove change. The MDS nurse stated she expected nurses to know that the wound was to be cleansed from the inside center to the outer edge of the wound bed using a separate moistened cleansing 4X4 gauze pad each time. She stated she expected nurses to use a separate cleaning wipe for the outer skin prior to cleansing the wound. 2. Resident #32 was admitted to the facility on 10/29/17, with multiple diagnoses including cancer of the liver and colon, obstructive and reflux uropathy.	F 880	Audits to begin on 5/24/18 and results reviewed in QAPI committee.		

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

PRINTED: 06/05/2018
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 05/04/2018
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 880	<p>Continued From page 28</p> <p>Resident #32's MDS quarterly assessment dated 3/29/18, documented Resident #32 had normal cognition. An MDS assessment dated 3/29/18, also documented Resident #32 required the assistance or supervision of one person for transfers, toileting, personal hygiene, dressing and bathing.</p> <p>The facility policy and procedure for catheter care dated 5/2007, documented staff were not to place urinary catheters on the floor.</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated 10/24/16, recommendation for proper techniques for urinary catheter maintenance documented not to rest the catheter bag on the floor.</p> <p>Residents #32's care plan dated 1/13/18, documented Resident #32 is at increased risk for infections due to chemotherapy.</p> <p>Residents #32's ADL care plan dated 10/29/17, documented Resident #32 had a self-care performance deficit related to generalized weakness, cancer.</p> <p>On 4/30/18 at 2:33 PM, Resident #32's urinary catheter tubing was dragging on the floor under his wheelchair.</p> <p>On 4/30/18 at 2:35 PM, Physical Therapy Aide (PTA) #1 passed by Resident #32 in the hall and did not react to his urinary catheter tubing dragging on the floor under his wheelchair.</p> <p>On 4/30/18 at 5:05 PM, Resident # 32 was observed in his arm chair with several inches of</p>	F 880			

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 05/04/2018
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 880	<p>Continued From page 29 urinary catheter tubing on the floor.</p> <p>On 5/1/18 at 4:52 PM, Resident #32's urinary catheter tubing was laying on the floor.</p> <p>On 5/3/18 at 7:12 AM, Resident #32's urinary catheter tubing was laying on the floor beside his chair.</p> <p>On 5/3/18 at 7:33 AM, LPN #1 observed Resident #32's urinary catheter tubing and said it should not be on the floor. LPN #1 did not reposition the tubing or speak to Resident #32 about the tubing observed on the floor.</p> <p>On 5/3/18 at 8:12 AM, Resident #32's urinary catheter tubing was on the floor.</p> <p>On 5/3/18 at 8:48 AM, PTA #1 stated she had not noticed anything about the urinary catheter tubing on 4/30/18 as she passed by. She stated if she had noticed, she would have alerted staff.</p> <p>On 5/3/18 at 8:58 AM, the MDS nurse stated Resident #32's urinary catheter bag should not have been on the floor and if it was on the floor, it would need to be cleaned and repositioned off the floor.</p> <p>3. Resident #46 was admitted to the facility on 10/11/17 with multiple diagnoses, including obstructive and reflux uropathy.</p> <p>The resident's 10/20/17 urinary care plan documented an intervention for an indwelling urinary catheter.</p> <p>Resident #46's active physician's orders</p>	F 880			

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

PRINTED: 06/05/2018
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 05/04/2018
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 880	Continued From page 30 documented an indwelling urinary catheter was ordered on 10/11/17. On 5/1/18 at 8:52 AM, Resident #46 was observed in bed. The bed was raised to mid height and the bottom of the resident's urinary privacy bag was in contact with the floor. On 5/1/18 at 9:21 AM, the bottom of Resident #46's urinary privacy bag was observed in contact with the floor. RN #1 was in the room at the time. RN #1 said the urinary privacy bag should not be on the floor, then adjusted the privacy bag to suspend on the bed frame.	F 880			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 15, 2019

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

Provider #: 135018

Dear Mr. Sievers:

On **May 4, 2018**, an unannounced on-site complaint survey was conducted at Monte Vista Hills Healthcare Center. The complaint was investigated during the federal recertification survey conducted at the facility on April 30, 2018 through May 4, 2018.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007790

ALLEGATION:

A nurse refused to administer an as needed medication and a resident was in pain for several hours.

FINDINGS:

Three pain medications were observed as they were administered to three residents during the survey. One of the pain medications was ordered on a scheduled basis, the other two pain medications were ordered on an as needed, or PRN, basis. All of the pain medications were administered in a timely manner.

Several residents were asked about the timeliness of their pain medication and the facility's management of their pain. All of the residents said their pain medication was administered timely and their pain was adequately managed.

Four nurses, one nurse manager, and the Director of Nursing were interviewed about pain medications.

Andrew Sievers, Administrator
January 15, 2019
Page 2 of 2

All of the nurses said they assess the resident, review the resident's orders and medication administration records, and respond promptly to a resident's request for pain medication. The nurses said they would inform the resident if it was too soon for a PRN medication and would notify the physician if the resident's pain was not managed with the current ordered medication(s). One Certified Nursing Assistant (CNA) was interviewed about residents' complaints of pain and requests for pain medication. The CNA said she would promptly notify the nurse if a resident complained of pain and/or requested something for pain.

The clinical records of twelve residents were reviewed for quality of care concerns, including pain management. Concerns regarding the timeliness of pain medication administration and pain management were not identified in the records.

The facility's Grievance files from November 2017 through April 2018 were also reviewed. One grievance documented a nurse "misread" a medication record and told a resident it was too soon to administer PRN Valium. The resident's Valium was ordered every eight hours PRN muscle spasms. The grievance documented the nurse "refused" to administer the Valium and the resident was in pain because pain medication was not given for eleven hours.

The facility's investigation of the grievance documented it was "unclear" when the resident requested the medication at 2:00 AM or 5:00 AM, a nurse "read the date wrong" and thought the Valium had been administered at 12:19 AM on the day of the request. The grievance also documented the resident "declined" the Valium when it was offered later that morning and the controlled substance records for the resident's Valium and oxycodone were accurate.

Based on the above information, it was determined the allegation was substantiated but the deficiency was corrected and not cited.

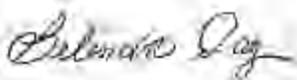
CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj