



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 6, 2019

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

Provider #: 135018

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Sievers:

On **January 29, 2019**, a Facility Fire Safety and Construction survey was conducted at **Monte Vista Hills Healthcare Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 19, 2019**. Failure to submit an acceptable PoC by **February 19, 2019**, may result in the imposition of civil monetary penalties by **March 13, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 5, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 29, 2019**. A change in the seriousness of the deficiencies on **March 15, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 5, 2019**, includes the following:

Denial of payment for new admissions effective **April 29, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 29, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 29, 2019**, 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:

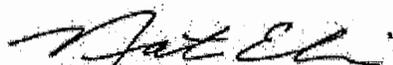
BFS Letters (06/30/11)

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

This request must be received by **February 19, 2019**. If your request for informal dispute resolution is received after **February 19, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

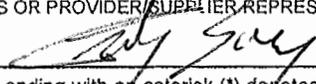
Printed: 02/05/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  The facility is a single story, type V (III) structure with a partial basement, originally constructed in 1963. The building is fully sprinklered and is equipped with an interconnected fire alarm/smoke detection system. The facility is located within a municipal fire district with both county and state EMS services available. Currently the facility is licensed for 113 SNF/NF beds and had a census of 62 on the date of the survey.  The following deficiencies were cited during the annual fire/life safety survey conducted on January 29, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70 and 483.80.  The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<p style="text-align: center;"><b>RECEIVED</b> <b>FEB 19 2019</b> <b>FACILITY STANDARDS</b></p>	
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101  General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate implementation of a water management program for waterborne pathogens such as Legionella, in accordance with 42 CFR 483.80. Failure to implement a water	K 100		1. Water management policies and procedures have been updated to include a risk assessment and system mapping of the fire suppression system. Water heater control measure policy was updated on 2/12/19. 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to maintenance director that water management plan is to include the fire suppression system. Also, to follow control measures in water management as written. (continued)

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

TITLE

(X6) DATE



Executive Director

2/15/19

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

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K 100	<p>Continued From page 1</p> <p>management program with consideration for the ASHRAE 188 standard and utilizing those parameters as defined in the CDC toolkit, has the potential to limit relevant facility awareness and expose residents to Legionella and other water source bacterium based on inconclusive data. This deficient practice affected 62 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of provided policies and procedures for water management conducted on 1/29/19 from 11:00 AM - 12:00 PM, records demonstrated the facility had not included the fire suppression system in its documentation of the the facility water system mapping, risk assessment or listed control measures.</p> <p>Further review of the plan failed to demonstrate documentation of monitoring those control measures identified, specifically flushing of water heaters with chlorine levels introduced at 30 ppm.</p> <p>Interview of the Maintenance Director revealed no flushing of water heaters was being conducted prior to the date of the survey.</p> <p>CFR standard: 42 CFR 483.80</p> <p>Additional reference: Center for Medicaid/Medicare Services S&amp;C 17-30</p>	K 100	<p>4. Maintenance Supervisor or designee will monitor control measures and document findings monthly for three months. Audits will be reviewed by the QAPI committee until it has been determined that the systems are effective.</p>	
K 211 SS=F	<p>Means of Egress - General CFR(s): NFPA 101</p> <p>Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance</p>	K 211	<p>1. Signs for delayed egress were ordered and placed on main exit door by Administrator's office, activity room, exit by rooms 201 and 202, by south dining (continued)</p>	2/15/19

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K 211	<p>Continued From page 2</p> <p>with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress were maintained in accordance with NFPA 101. Failure to ensure doors equipped with delayed egress were signed indicating the function of the system, has the potential to hinder evacuation of residents during an emergency. This deficient practice affected 24 residents, staff and visitors in 3 of 8 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/29/19 from 11:00 AM - 12:00 PM, observation of the exit doors in the facility revealed all were equipped with magnetic locking arrangements. Further observation of these doors established the following doors were not equipped with the signs required indicating the operation of the delayed egress component of the door:</p> <p>Main exit door by the Administrator's office and the Activity room Exit door by room(s) 201 and 202 Exit door by South Dining area Exit door abutting the conference room</p> <p>Actual NFPA Standard:</p> <p>7.2.1.6* Special Locking Arrangements. 7.2.1.6.1 Delayed-Egress Locking Systems. 7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed</p>	K 211	<p>area, and by conference room on 2/13/19.</p> <p>2. All residents, staff, and visitors have potential to be affected by this practice.</p> <p>3. In-service to maintenance director that all exit doors equipped with magnetic locking arrangements must be equipped with signs indicating the operation of the delayed egress component.</p> <p>4. Maintenance Supervisor or designee will conduct an audit of all exit doors equipped with magnetic locking arrangements to ensure each is equipped with signs indicating operation of delayed egress monthly for three months. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.</p>	

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K 211	<p>Continued From page 3</p> <p>on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>(4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1.8</p>	K 211		

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K 211	Continued From page 4 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 211		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to inspect system components in accordance with the scheduling required under the standard, has the potential to hinder system performance during	K 353	1. Documentation form of both dry system gauge's and wet control valves were created and inspection completed 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to maintenance supervisor that dry gauge's and wet control valves are to be checked weekly and document results. 4. Maintenance Supervisor or designee will conduct an audit of all dry system gauge's and wet control valves to ensure each is properly documented, ongoing. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.	2/15/19

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K 353	Continued From page 5 a fire event. This deficient practice affected 62 residents, staff and visitors on the date of the survey.  Findings include:  During review of provided facility inspection and testing records conducted on 1/29/19 from 11:00 AM - 12:00 PM, only 1 of 16 weekly inspections indicated dry system gauge inspections were documented. Further review of provided maintenance records, failed to demonstrate monthly inspection of wet system control valves were being conducted.  Actual NFPA standard:  NFPA 25  5.2.4 Gauges. 5.2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained.  Chapter 13 Valves, Valve Components, and Trim  13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with	K 511	1. Extension cords were removed from room 128 and 131 on 1/29/19.  (continued)	2/15/19

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K 511	<p>Continued From page 6 NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Failure to ensure electrical installations are approved and in accordance with applicable standards, has the potential to expose residents to electrocution and inadvertant arc fires. This deficient practice affected 6 residents, staff and visitors in 1 of 8 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/29/19 from 11:00 AM - 3:00 PM, observation of resident room(s) 128 and 131 revealed both were using 3-1, non-grounded extension cords to supply power to resident electronics. Further observation of room 128 established the extension cord was daisy-chained into a relocatable power tap (RPT).</p> <p>Actual NFPA standard:</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p>	K 511	<p>2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to maintenance supervisor and staff that non grounded extension cords are not to be used in the building. Also, that RPT's are not to be daisy-chained to extension cords. 4. Maintenance supervisor or designee will conduct an audit of all rooms for extension cords weekly for four weeks and monthly for three months. The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.</p>	

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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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K 511	Continued From page 7 110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.	K 511		
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101	K 923	1. All "E" cylinders were returned to either Norco or Airgas.  (continued)	2/15/19

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

Printed: 02/05/2019  
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 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/29/2019</b>	
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K 923	<p>Continued From page 8</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>&gt;300 but &lt;3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure medical gas cylinders were maintained in</p>	K 923	<p>Each individual liquid oxygen cylinder (LOX) was secured with a cart.</p> <p>2. All residents, staff, and visitors have potential to be affected by this practice.</p> <p>3. In-service to maintenance supervisor and staff that any "E" cylinders must be separated from full and empties and that all cylinders must be secure with cart.</p> <p>4. Maintenance supervisor or designee will conduct an audit weekly for four weeks and monthly for three months of the oxygen storage room to ensure all cylinders are properly secured and if any "E" cylinders enter the building they are correctly stored and separated.</p> <p>The audits will be reviewed monthly by the QAPI committee until it has been determined that the systems are effective.</p>	

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K 923	<p>Continued From page 9</p> <p>accordance with NFPA 99. Failure to secure stored oxygen cylinders and segregate full cylinders from empty, has the potential to inadvertently use the incorrect cylinder during an emergency requiring supplemental oxygen. Failure to secure compressed medical gas cylinders from falling potentially exposes residents to explosions and those increased risks associated. This deficient practice affected 11 residents in 1 of 8 smoke compartments, residents requiring supplemental oxygen treatment, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 1/29/19 from 11:00 AM - 3:00 PM, observation of the oxygen storage room abutting room 204 and 206, revealed two sections with oxygen storage, one marked "Full" and one marked "Empty". Further observation revealed two (2) cylinders whose gauges indicated "Full", placed in portable rack on the side marked "Empty".</p> <p>2) During the facility tour conducted on 1/29/19 from 11:00 AM - 3:00 PM, observation of the oxygen storage room abutting room 204 and 206, revealed two (2) "E" cylinders laying loose on the wooden storage shelving and three (3) Liquid oxygen cylinders (LOX), unsecured by a rack or cart.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures:</p>	K 923		

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K 923	Continued From page 10 (1) Oxygen cylinders shall be protected from abnormal mechanical shock, which is liable to damage the cylinder, valve, or safety device. (2) Oxygen cylinders shall not be stored near elevators or gangways or in locations where heavy moving objects will strike them or fall on them. (3) Cylinders shall be protected from tampering by unauthorized individuals. (4) Cylinders or cylinder valves shall not be repaired, painted, or altered. (5) Safety relief devices in valves or cylinders shall not be tampered with. (6) Valve outlets clogged with ice shall be thawed with warm - not boiling - water. (7) A torch flame shall not be permitted, under any circumstances, to come in contact with a cylinder, cylinder valve, or safety device. (8) Sparks and flame shall be kept away from cylinders. (9) Even if they are considered to be empty, cylinders shall not be used as rollers, supports, or for any purpose other than that for which the supplier intended them. (10) Large cylinders (exceeding size E) and containers larger than 45 kg (100 lb) weight shall be transported on a proper hand truck or cart complying with 11.4.3.1. (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. (12) Cylinders shall not be supported by radiators, steam pipes, or heat ducts.  11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.	K 923		

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K 923	Continued From page 11 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.  11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.  11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity: (1) Securing to a fixed object with one or more restraints (2) Securing within a framework, stand, or assembly designed to resist container movement (3) Restraining by placing the container against two points of contact	K 923			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

February 6, 2019

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

Provider #: 135018

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Sievers:

On **January 29, 2019**, an Emergency Preparedness survey was conducted at **Monte Vista Hills Healthcare Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567

Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 19, 2019**. Failure to submit an acceptable PoC by **February 19, 2019**, may result in the imposition of civil monetary penalties by **March 13, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 5, 2019**, (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 . A change in the seriousness of the deficiencies on **March 23, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 5, 2019**, includes the following:

Denial of payment for new admissions effective **April 29, 2019**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

Andrew Sievers, Administrator

February 6, 2019

Page 3 of 4

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 29, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 29, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

Andrew Sievers, Administrator

February 6, 2019

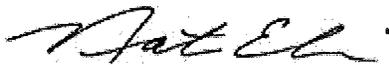
Page 4 of 4

This request must be received by **February 19, 2019**. If your request for informal dispute resolution is received after **February 19, 2019**, the request

will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj

Enclosures

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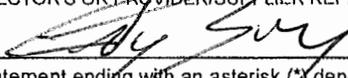
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E 000	Initial Comments  The facility is a single story, type V (III) structure with a partial basement, originally constructed in 1963. The building is fully sprinklered and is equipped with an interconnected fire alarm/smoke detection system. The facility is located within a municipal fire district with both county and state EMS services available. Emergency backup power is provided by a spark-fired, natural gas Emergency Power Supply System (EPSS) generator. Currently the facility is licensed for 113 SNF/NF beds and had a census of 62 on the date of the survey.  The following deficiencies were cited during the Emergency Preparedness Survey conducted on January 29, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.  The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	E 000			
E 015 SS=E	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:  (1) The provision of subsistence needs for staff	E 015	1. A policy and procedure for loss of sewage and waste disposal in the event of a disaster and added to our Emergency Operation Plan. 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to staff of the updated policy for sewage and waste disposal in the event of a disaster. (continued)	2/15/19	

**RECEIVED**  
**FEB 19 2019**  
**FACILITY STANDARDS**

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

TITLE

(X6) DATE



Executive Director

2/15/19

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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E 015	<p>Continued From page 1</p> <p>and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(i) Food, water, medical and pharmaceutical supplies</p> <p>(ii) Alternate sources of energy to maintain the following:</p> <p>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to develop policies and procedures in the Emergency Operations Plan (EOP), which</p>	E 015	<p>4. Maintenance Supervisor or designee will conduct audits of the policies and procedures in the Emergency Operations Plan quarterly. The audits will be reviewed by the QAPI committee until it has been determined that the systems are effective.</p>		

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E 015	Continued From page 2 identified the steps or methods for providing sewage and waste disposal should those utilities become compromised in a disaster requiring the need to shelter in place. Lack of policies and procedures for sewage and waste disposal during a disaster, has the potential to limit the ability to provide continuing care for residents housed in the facility. This deficient practice affected 62 residents, staff and visitors on the date of the survey.  Findings include:  On 1/29/19 from 9:00 - 11:00 AM, review of provided policies and procedures did not reveal a policy or procedure for utilities loss that was relevant to the loss of sewage and waste disposal during a disaster.  Reference: 42 CFR 483.73 (b) (1)	E 015			
E 031 SS=D	Emergency Officials Contact Information CFR(s): 483.73(c)(2)  [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:  (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance.  *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff.	E 031	1. Agency phone numbers were corrected on page 3 and 5-20 for the State Licensing and Certification agency. 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to staff of the updated contact information in the Emergency Operations Plan. 4. Maintenance Supervisor or designee will conduct quarterly audits of the emergency contact phone numbers in the EOP. The audits will be reviewed by the QAPI committee until it has been determined that the systems are effective.	2/15/19	

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E 031	<p>Continued From page 3</p> <p>(ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the communication plan of the EOP. Failure to provide contact information for the State Licensing and Certification Agency has the potential to hinder facility response and continuity of care for the 62 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 1/29/19 from 9:00 - 11:00 AM, review of the provided EOP, revealed the phone numbers listed for the Licensing and Certification agency on pages 3 and 5 - 20, were not the correct number for the agency. At 10:36 AM, the phone number listed on pages 5 - 20 was dialed and was confirmed to actually belong to a business that identified themselves as a private business and not the State Licensing and Certification Agency.</p> <p>Reference: 42 CFR 483.73 (c) (2)</p>	E 031	
(X5) COMPLETION DATE			

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

Printed: 02/05/2019  
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>01/29/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>MONTE VISTA HILLS HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1071 RENEE AVENUE POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 036 E 036 SS=D	Continued From page 4 EP Training and Testing CFR(s): 483.73(d)  (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.  *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).  *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.	E 036 E 036	1. Staff were tested on the Emergency operation plan. 2. All residents, staff, and visitors have potential to be affected by this practice. 3. In-service to maintenance supervisor that testing of the staff on the EOP must be done yearly. 4. Maintenance supervisor or designee will set a yearly testing schedule for staff on the EOP and the schedule and test will be reviewed by QAPI.	2/15/19	

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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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E 036	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a staff testing program covering training topic in the EOP, has the potential to hinder staff response during a disaster. This deficient practice affected 62 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/29/18 from 9:00 - 11:00 AM, review of the provided EOP, along with associated inservices, found no documentation demonstrating the facility had a current testing program for staff based on training conducted over the EOP contents.</p> <p>Interview of the Administrator conducted on 1/29/19 from 9:30 - 11:45 AM, established the facility had established a training program on the EOP, but had yet to implement a testing process in conjunction with that training.</p> <p>Reference: 42 CFR 483.73 (d)</p>	E 036			