

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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</b></p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an advanced directive. This was true for 1 of 16 residents (Resident #25) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include:</p> <p>The facility's Advanced Directives and Associated Documentation policy, revision date December 2023, documented it is the policy of this facility that a resident's choice about advance directives will be recognized and respected. It is the policy of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advanced directive. The facility will obtain a copy of the advanced directive documents and place the documents in the resident health record.</p> <p>Resident #25 was admitted to the facility on [DATE], with multiple diagnoses including stroke and dementia.</p> <p>A Medical Treatment Decisions form, dated 8/3/21, documented Resident #25 had an advanced directive and had presented her advanced directive to the Admissions Coordinator.</p> <p>Resident #25's care plan, dated 8/3/21, did not include an advanced directive decision.</p> <p>On 7/25/24 at 4:01 PM, the DON stated Resident #25 did not have an advanced directive but did have a POST and a DPOA. She also stated Resident #25's advanced directive decisions should have been included in her care plan.</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  135018	Facility ID:  135018  If continuation sheet Page 1 of 17

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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</b></p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to ensure continuity of care by not providing pertinent health information to the receiving hospital. This was true for 4 of 6 residents (#19, #33, #34, and #55) reviewed for transfers. This deficient practice had the potential to result in adverse outcomes if residents were not treated in a timely manner due to the lack of information provided upon transfer. Findings include:</p> <p>The facility's Criteria for Transfer and Discharge policy, dated December 2023, documented, information provided to the receiving provider must include a minimum of the following:</p> <ul style="list-style-type: none"> <li>a. Contact information of the practitioner responsible for the care of the resident.</li> <li>b. Resident representative information including contact information.</li> <li>c. Advance Directive information.</li> <li>d. All special instructions or precautions for ongoing care, as appropriate, to include but is not limited to treatments and devices, transmission-based precautions, and special risks (e.g., falls, elopement, aspiration, or pressure injury).</li> <li>e. Comprehensive care plan goals; and</li> <li>f. All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.</li> </ul> <p>The following resident records did not include documentation that pertinent resident health information had been sent to the hospital upon their transfer:</p> <p>1. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy (a chemical imbalance in the blood that damages the brain), sepsis, urinary tract infection, diabetes, severe protein-calorie malnutrition, and acute kidney failure.</p> <p>LPN #1 noted on 7/16/24 at 10:13 AM, due to lab work results, Resident #19 was transferred to the hospital and admitted for hyponatremia and abnormal renal function.</p> <p>A nurses note, dated 7/16/24 at 6:14 PM, documented Resident #19's daughter was notified of the hospital transfer and admit.</p> <p>Resident #19's medical record did not include documentation that her advance directive, comprehensive care plan, or other pertinent resident health information had been sent to the hospital.</p> <p>On 7/26/24 at 9:45 AM, the DON stated there was no documentation of what information was sent with Resident #19 to the hospital.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Resident #34 was admitted to the facility on [DATE], with multiple diagnoses including gastrointestinal hemorrhage, severe protein-calorie malnutrition, COPD, and diabetes.</p> <p>A Nursing Home to Hospital Transfer form, dated 5/28/24, documented Resident #34 was transferred to hospital for gastrointestinal bleeding.</p> <p>A nurses note, dated 5/28/24, documented, resident left facility with POST form, admission form, and med list. Resident #34's medical record did not include documentation that her advance directive, comprehensive care plan, or other pertinent resident health information had been sent to the hospital.</p> <p>On 7/25/24 at 3:54 PM, the DON confirmed that the care plan and advanced directives were not sent to the hospital.</p> <p>3. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including acute osteomyelitis of the left ankle and foot, sepsis, chronic ulcer on part of left foot, diabetes, and morbid obesity.</p> <p>A nurses note, dated 5/27/24, documented Resident #55 was transferred to the hospital with new onset, foul drainage from his left foot ulcer.</p> <p>A nurses note, dated 5/27/24 at 2:06 PM, noted Resident #55's brother was notified of his transfer to the hospital.</p> <p>On 7/25/24 at 5:05 PM, the DON stated there was no documentation in Resident #55's record of what information was sent to the hospital. Additionally, the DON confirmed there was no physician's order for his transfer to the hospital.</p> <p>50983</p> <p>4. Resident #33 was admitted to the facility on [DATE], with multiple diagnoses including metabolic encephalopathy, sepsis, and pneumonia.</p> <p>Resident #33's record documented she was transported and admitted to the hospital on 2/29/24, with a diagnosis of pneumonia and again on 5/25/24, with a diagnoses of acute chronic respiratory failure and sepsis secondary to pneumonia.</p> <p>Resident #33's record did not include documentation of the information that was provided to the hospital upon Resident #33's transfer.</p> <p>On 7/26/24 at 11:58 AM, the SSD, who is responsible for transfer and discharge documentation and notification, stated he was not aware of what documentation was needed for a hospital transfer.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733</b></p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of practice and comprehensive care plans were followed for 2 of 16 residents (Residents #17 and #41) reviewed for quality of care. Resident #17 was at risk of wound infection when her wound care was not performed as directed by her care plan. Resident #41 was at risk for adverse outcomes when his urinary catheter tubing was not secured as directed by his care plan. Findings include:</p> <p>1. Resident #17 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including orthopedic aftercare following surgical amputation of lower right extremity and morbid obesity.</p> <p>Resident #17's MAR included the following wound care interventions which were not completed as ordered by her physician and care plan:</p> <ul style="list-style-type: none"> <li>- Monitor wound vac each shift to ensure properly functioning, do not change dressing. If issues are noted, then reinforce dressing only and notify physician. Dressing will be completed in the orthopedic office. Order start date 1/18/23. Order discontinued date 2/12/23. The wound monitoring was not documented as completed for the dayshift on 1/19/23, 1/20/23, 1/21/23, 1/26/23, and 1/27/23.</li> <li>- Wound care RLE (right lower extremity). Clean with wound cleanser or NS (normal saline). Cover with a dry dressing. Change daily and as needed for wound care. Order start date 1/26/23. Order discontinued date 1/29/23. The wound care was not documented as completed on 1/26/23 and 1/27/23.</li> <li>- Leave incision to right leg open to air every shift. Order start date 11/28/22. Order discontinued date 1/12/23. The wound care was not documented as completed for the dayshift on 12/2/23, 12/4/23, 12/8/23, 12/22/23, 12/31/23, and for nightshift on 12/17/23 and 12/23/23.</li> </ul> <p>During an interview on 7/26/24 at 11:35 AM, the DON reviewed Resident #17's record and confirmed her wound care was not performed as directed by physician orders and the care plan, and there was no further documentation as to why the wound care was not completed.</p> <p>49552</p> <p>2. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including traumatic subdural hemorrhage, diabetes, malnutrition, and respiratory failure.</p> <p>Resident #41's physician's order, dated 7/28/22, documented every shift staff were to ensure the catheter is secured to facilitate flow of urine, prevent kinking of tubing, and accidental removal.</p> <p>Resident #41's care plan, directed staff to secure catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal.</p> <p>On 7/24/24 at 9:36 AM, Resident #41's foley catheter tubing was observed, with CNA #2 present, and found not to be secured.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/25/24 at 5:06 PM, Resident #41's foley catheter tubing was observed, with the DON present, and found not to be secured.</p> <p>On 7/25/24 at 5:08 PM, the DON stated Resident #41 should have had his catheter tubing secured to his leg to prevent it from being pulled out.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36190</p> <p>Based on observation, interview, and record review, the facility failed to ensure positioning devices were in place to prevent further contractures for 1 of 1 resident (Resident #6) reviewed for range of motion. This deficient practice could result in further contractures and pain for Resident #6. Findings include:</p> <p>A facility policy for range of motion was requested and not provided.</p> <p>Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including traumatic brain dysfunction, quadriplegia (a symptom of paralysis that affects all a person's limbs and body from the neck down), and contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).</p> <p>Resident #6's annual MDS, dated [DATE], documented Resident #6's cognition was severely impaired and her upper extremity (shoulder, elbow, wrist, hand) had impairment on both sides.</p> <p>A physician order, dated 5/27/22, documented, Encourage use of carrots [a positioning device] or rolled up washcloth in bilateral hands as she will accept to assist with contracture prevention.</p> <p>Resident #6's care plan, revised 7/23/24, directed staff to, Encourage (carrots) or rolled up washcloths to bilateral hands as she will accept/tolerate (does often refuse and remove) to assist with prevention of further contractures and ROM limitations.</p> <p>A TAR, dated July 2024, documented Resident #6 had the carrots or rolled up washcloths in place during the dayshift on 7/22/24, 7/23/24, and 7/24/24.</p> <p>On 7/22/24 at 11:45 AM, Resident #6 was observed sitting in her wheelchair in the hallway. Resident #6's hands were contracted as she held them against her chest. No positioning devices were in her hands.</p> <p>On 7/23/24 at 2:50 PM, Resident #6 was observed awake in bed and holding her contracted hands against her chest. No positioning devices were in her hands.</p> <p>On 7/24/24 at 10:27 AM, Resident #6 was observed asleep in bed and holding her contracted hands against her chest. No positioning devices were in her hands.</p> <p>On 7/24/24 at 2:37 PM, Resident #6 was observed asleep in bed and holding her hands against her chest. No positioning devices in her hands.</p> <p>Progress notes, dated 7/22/24, 7/23/24, and 7/24/24, did not include documentation of Resident #6 refusing the positioning devices in her hands.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/24/24 at 3:03 PM, LPN #2 was asked about Resident #6's positioning devices. LPN #2 confirmed Resident #6 did not have the positioning devices in her hands stating, she has them but will refuse to use them. LPN #2 looked in Resident #6's room for the positioning devices and came out of the room stating she could not find them. LPN #2 then stated, the laundry may have it. LPN #2 stated sometimes Resident #6 will get the positioning devices soiled during breakfast when RNA #1 feeds her and RNA #1 may have put it in the laundry.</p> <p>On 7/25/24 at 11:52 AM, RNA #1 was asked if Resident #6 had positioning devices in her hands during this week and RNA #1 said, No.</p> <p>On 7/25/24 at 4:51 PM, CNA #6 was asked if Resident #6 used positioning devices for her contractures and CNA #6 stated, No, she's never seen any carrots or wash cloths for her hands.</p> <p>On 7/26/24 at 9:57 AM, the DON stated she was not aware the TAR documented Resident #6 had the positioning devices in her hands, but Resident #6's refusals were not documented.</p> <p>On 7/26/24 at 10:24 AM, the PTA was asked about Resident #6's carrots for her hands. The PTA stated he had provided Resident #6 with positioning devices about two months ago, and they should be in her room and should be used.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36190</p> <p>Based on interview, record review, and policy review, it was determined the facility failed to ensure staff used a gait belt per the policy during a transfer that resulted in a potential for more than minimal harm for 1 of 5 residents (Resident #116) reviewed for accidents. Findings include:</p> <p>Resident #116 was admitted to the facility on [DATE], with multiple diagnoses including status-post left hip fracture, osteoporosis, Parkinson's disease, and arthritis.</p> <p>Resident #116's admission MDS, dated [DATE], stated Resident #116 was cognitively intact; height was 63 inches and weight was 202 pounds and required substantial/maximal assistance with chair/bed-to-chair transfer.</p> <p>A care plan, dated 11/6/23, stated, ADL Self Care Performance Deficit r/t [related to] acute illness, Parkinson's disease, S/P [status post] left hip fracture. An intervention included, Transfer (chair/bed to chair transfer, toilet transfer): Requires dependent assist, 2 person mechanical lift, dated 11/16/23.</p> <p>A fall risk evaluation, dated 11/8/23 stated Resident #116 was a high risk for falls, had a history of falls, and had balance problems while standing/walking.</p> <p>A nursing note, dated 12/8/24, stated Resident #116 was assisted by COTA #1 resulting in a complaint of pain in her left hip and a skin tear to her left hand. Resident #116 was transferred to the hospital for assessment.</p> <p>Physician progress notes, dated 12/29/24, stated Resident #116 was admitted to the hospital on 12/08/23 with a left femoral fracture (periprosthetic [close to implant], both distal and proximal).</p> <p>The facility investigation, dated 12/8/23, documented the following:</p> <p>Resident #116 lost her balance and was assisted to the floor by COTA #1 during a transfer from a wheelchair to a recliner. Resident #116 was taken to the hospital and a left periprosthetic femoral fracture was found and surgical repair was performed.</p> <p>COTA #1's statement documented, I was helping resident transfer from wheelchair to recliner. I placed the walker in front of the resident and put a hand under her right arm to give her a boost up, because she has been transferring well lately. Resident lost her balance and had a moderate fall backwards, more to her left side. She was mostly on her left buttock when she was on the floor. I immediately notified nursing while I supported resident upper body in sitting position on the floor.</p> <p>The facility investigation conclusion documented staff were trained on 12/8/23 regarding ensuring residents are wearing non skid footwear during transfers, locking wheelchair brakes, and using a gait belt during transfers.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/25/24 at 6:40 PM, COTA #1 was asked if she used a gait belt during Resident #116's transfer. She stated she normally used a gait belt, but could not remember if she used a gait belt during Resident #116's transfer on 12/8/23. COTA #1 confirmed Resident #116 was a two-person transfer for the CNAs, but she did not use a second person because therapy listed Resident #116 as a moderate assist, requiring one person.</p> <p>On 7/26/24 at 10:15 AM, the PTA stated COTA #1 should have used two-persons to transfer Resident #116 on 12/8/23, and confirmed COTA #1 did not utilize a second person. The PTA was asked if it was their policy to use a gait belt for Resident #116 and was a gait belt used when Resident #116 fell . He stated it was their policy and confirmed it was not documented that COTA #1 used a gait belt during resident #116's transfer on 12/8/23.</p> <p>On 7/26/24 at 1:52 PM, the Administrator stated for all staff, including therapy staff, are expected to follow the care plan and use a gait belt for transfers.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49552</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to secure and label unidentified loose pills in 1 of 1 medication cart (North side medication cart), audited for labeling and storage of medication. This failure created the potential for residents to miss doses of medication. Findings include:</p> <p>The facility's Medication Access and Storage policy, revision date May 2023, documented:</p> <ul style="list-style-type: none"> <li>- The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers.</li> <li>- Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order exists.</li> <li>- Medication storage areas are kept clean, well lit, and free of clutter.</li> </ul> <p>On 7/24/24 at 2:39 PM, a North side medication cart audit was completed with LPN #1 present. The following was found:</p> <ul style="list-style-type: none"> <li>- 4 unidentified pink pills loose in the second drawer.</li> <li>- 3 unidentified blue pills loose in the second drawer.</li> <li>- 1 unidentified half of a brown tablet loose in the second drawer.</li> <li>- 10 unidentified white pills, different sizes, loose in the second drawer.</li> </ul> <p>On 7/24/24 at 2:44 PM, LPN #1 stated she did not know why the pills were on the bottom of the drawer and she was not sure whose job it was to check the medication cart for loose pills.</p> <p>On 7/25/24 at 11:09 AM, the DON stated the nurses should check the medication cart throughout their shift and destroy loose medication in the drug buster bottle. If it is a narcotic it is destroyed by 2 nurses. She also stated she was not sure if pharmacy checks the carts when they are in the facility. The DON stated the medication cart audits are done by the DON but, there is not documentation of the audit being done, what they are looking for, or what they found.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>36190</p> <p>Based on interview and record review, the facility failed to employ a qualified director of food and nutrition services. This deficient practice had the potential to affect 61 of 62 residents who received meals prepared in the facility's kitchen. Findings include:</p> <p>A printout of the Dietary Manager certification training program stated the Dietary Supervisor (DS) had completed 34% of the course since it was started 1/4/24.</p> <p>On 7/23/24 at 4:06 PM, the DS was asked if she was certified as a Dietary Manager. She stated she was not, but she had been working as the Dietary Manager at the facility since April of 2023. The DS stated she had ten years of food service experience in restaurants but none in healthcare. She stated she had her food handler's certification and had not completed other courses in food safety and management.</p> <p>During an interview on 7/25/24 at 3:15 PM, the Administrator and RD confirmed the DS was currently enrolled in a qualifying course which would provide the DS with the credentials she needed to meet the regulation after completion of the course.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36190</p> <p>Based on observation, interview, policy review, and review of the Idaho and FDA Food Codes, the facility failed to appropriately store, distribute, and label foods; clean ovens; and perform appropriate hand hygiene. This deficient practice had the potential to affect 61 of 62 residents who received meals prepared in the facility's kitchen. Findings include:</p> <p>1. The Idaho Food Code, revised February 2021, stated ,d+[DATE].17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>The facility policy titled Food Labeling and Storage, undated, stated All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered and dated when stored and When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food.</p> <p>The facility policy titled Food Storage, undated, stated 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated, f. All foods should be covered, labeled and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their use by dates, or frozen (where applicable) or discarded, and c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded.</p> <p>A. On [DATE] at 10:44 AM and on [DATE] at 4:20 PM, the walk-in refrigerator was observed with the DS. Open containers were found that included:</p> <ul style="list-style-type: none"> <li>- a bottle of salad dressing with an expired use by date of [DATE].</li> <li>- a bottle of Italian dressing with an open date of [DATE] and a use by date of [DATE] with an open/exposed spout.</li> <li>- a bottle of Italian dressing with an open date of [DATE] and a use by date of [DATE] with an open/exposed spout.</li> <li>- a bottle of Ranch dressing with an open date of [DATE] and a use by date of [DATE] with an open/exposed spout.</li> </ul> <p>On [DATE] at 12:42 PM, the DS stated the salad dressings were homemade except the Ranch dressing and the Ranch dressing was removed from the original container. The DS stated she thought the USDA [United States Department of Agriculture] rule applied, keeping salad dressings up to 30 days.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 3:05 PM, the RD was asked about kitchen labeling, storing, cleaning the ovens, and handwashing practices. The RD confirmed the items in the walk-in refrigerator and mini freezer should have been protected from freezer burn and should have been labeled and dated.</p> <p>B. On [DATE] at 4:20 PM, the walk-in refrigerator was observed with the DS. An undated open/exposed bag of whipped cream was found. The DS stated staff should have placed it in a zip lock bag.</p> <p>C. On [DATE] at 10:44 AM, the mini freezer in the kitchen was observed with the DS. The freezer contained food products that were loosely wrapped/covered and did not contain a date or a label. These included a package of pancakes, two packages of French toast, two packages of hash browns, a package of onions/pepper mix, a double layer of trays with multiple single size servings of ice cream, a package of chicken cordon bleu, a package of chicken nuggets, a pizza, a package of biscuits covered in ice, and a package of chicken strips. The DS acknowledged the frozen items did not contain a date or label but felt the items wrapped in a plastic film was sufficient to prevent freezer burn.</p> <p>On [DATE] at 4:28 PM, the mini freezer in the kitchen was observed with the DS. The freezer contained an undated package of loosely wrapped chicken strips and ravioli. The DS acknowledged the frozen items did not contain a date or label and the items were only wrapped in plastic film.</p> <p>During an interview on [DATE] at 3:05 PM, the RD was asked about kitchen labeling, storing, cleaning the ovens, and handwashing practices. The RD confirmed the items in the walk-in refrigerator and mini freezer should have been protected from freezer burn and should have been labeled and dated. The RD stated she observed the trays of single servings of ice cream in the mini freezer and made recommendations to the DS.</p> <p>2. FDA Food Code Section ,d+[DATE].11 stated, EQUIPMENT, FOOD-CONTACT SURFACES, NONFOOD-CONTACT SURFACES, AND UTENSILS (A) (B) (C) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.</p> <p>The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>The facility's General Food Preparation and Handling policy, undated, stated:</p> <ul style="list-style-type: none"> <li>- The kitchen surfaces and equipment will be cleaned and sanitized as appropriate</li> <li>- Prepared food will be transported to other areas in covered containers</li> <li>- Bare hands should never touch ready to eat raw food directly. Disposable gloves are a single use item and should be discarded after each use. Employees should wash their hands prior to putting gloves on and after removing gloves.</li> </ul> <p>A. On [DATE] at 10:44 AM, the two standard ovens and stoves were observed with the DS. The bottom of the inside of both ovens contained a white dried residue and the two grease trays, below the stoves, contained food drainage. On [DATE] at 4:06 PM, the two standard ovens were observed to have the same white residue and both stove grease trays contained the same food drainage from the day before.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 4:06 PM, the DS stated the ovens and grease trays should be cleaned daily but she was not sure what the white residue was.</p> <p>B. On [DATE] at 10:55 AM and [DATE] at 4:11 PM, multiple clean trays, tubs, silverware, multiple plate bases and lids sitting on a back table were observed with the DS. These items were noted to be covered in a white residue.</p> <p>On [DATE] at 4:11 PM, DS stated the white residue was due to hard water. DS stated, the water softer machine had been down for one week and the last time the dishes were de-limed was one and a half months ago.</p> <p>C. On [DATE] at 4:46 PM, the refrigerator in the nutrition room on the south nurse station was observed with the DS and to contain an open container of frozen fruit, undated, and a container of fruit, with an expired date of [DATE].</p> <p>The DS confirmed the frozen fruit should have been disposed of on [DATE].</p> <p>D. On [DATE] at 7:31 AM, the [NAME] did not wash his hands between glove changes while plating breakfast foods on the steamtable.</p> <p>On [DATE] at 7:39 AM, the Dietary Aide did not wash her hands before donning gloves while assembling the breakfast trays.</p> <p>On [DATE] at 7:41 AM, the DS was observed handling the lid of the large trash can to discard her gloves and did not wash her hands prior to donning another pair of gloves at 7:42 AM, and handling toast while preparing for breakfast.</p> <p>The DS was asked about not washing her hands and the DS confirmed she should have washed her hands before donning the gloves.</p> <p>On [DATE] at 9:28 AM, the Dietary Aide touched the sink faucet with her bare hands after washing her hands and then proceeded to unload clean dishes from the dishwasher.</p> <p>During a follow up interview on [DATE] at 8:26 AM, the RD was asked about her expectation for sealing open foods, labeling foods, and handwashing. RD stated to follow their state food code which was to securely seal and label foods and wash hands when indicated.</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552</b></p> <p>Based on observation, policy review, and staff interview, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment, when staff did not clean resident's equipment, perform hand hygiene properly, and follow proper protocol when checking blood sugars, and administering insulin. These failures had the potential to impact 1 of 7 resident's (Resident #27) equipment observed for cleanliness, 1 of 1 resident (Resident #41) for catheter drainage bag care, and 2 of 4 residents (Resident #14 &amp; #41) who have their blood sugar checked and are on insulin. These deficient practices placed them at risk for cross-contamination and infection. Findings include:</p> <p>The facility's Hand Hygiene policy, revised December 2023, directs staff to use alcohol-based hand rub prior to donning gloves, removing gloves, before moving from a contaminated body site to a clean body site during resident care, and before and after handling urinary catheters.</p> <p>The U.S. Centers for Disease Control and Prevention, (CDC), Clinical Safety: Hand Hygiene for Healthcare Workers, (<a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety/">https://www.cdc.gov/clean-hands/hcp/clinical-safety/</a>), dated February 27, 2024, documents to change gloves and clean hands, when moving from a soiled body site to a clean body site on the same patient.</p> <p>The facility's Glucometer Cleaning and Decontamination policy, revised December 2020, directed staff to disinfect the exterior surface of the glucometer after each use, following the manufacturer's directions, using either an EPA-registered detergent/germicide with a tuberculocidal or HBV/HIV label claim.</p> <p>The Sani-Cloth guideline for use documented:</p> <ul style="list-style-type: none"> <li>- unfold a clean wipe and thoroughly wet surface.</li> <li>- allow treated surface to remain wet for 2 minutes.</li> <li>- let it air dry.</li> </ul> <p>The facility's Administering Insulin policy, revised March 2023, directed staff to swab rubber cap with alcohol sponge, when preparing the insulin syringe and needle.</p> <p>1. On 7/22/24 at 12:31 PM, CNA #6 delivered Resident #25's meal to her. CNA #6 did not offer hand hygiene to Resident #25.</p> <p>On 7/22/24 at 12:33 PM, CNA #6 stated I do wash their hands, but I must have spaced that one.</p> <p>On 7/22/24 at 12:36 PM, CNA #1 was observed passing meal trays to residents eating in their room. She did not offer to wash the resident's hands before setting up their meals.</p> <p>On 7/22/24 at 12:40 PM, CNA #1 stated, she did not offer to wash her hands and should have. We should be asking if they want their hands washed.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 7/23/24 at 2:30 PM, CNA #3 and CNA #4 were observed transferring Resident #27 using the Hoyer lift (an assistive device that allows resident to be transferred by the use of electrical power). The Hoyer lift was observed with a dry gray substance on the base of the machine. After Resident #27 was transferred, CNA #4 took the Hoyer lift down the hall to the storage room. CNA #4 did not clean the Hoyer lift after transferring Resident #27.</p> <p>On 7/23/24 at 2:43 PM, CNA #4 stated she was not sure when the Hoyer lifts were cleaned.</p> <p>On 7/23/24 at 2:44 PM, Housekeeper #1 stated Hoyer lifts should be cleaned after every use.</p> <p>On 7/23/24 at 2:46 PM, CNA #3 stated the Hoyer lift should have been cleaned after transferring Resident #27.</p> <p>On 7/26/24 at 11:53 AM, the DON stated Hoyer lifts should be cleaned by the CNAs between residents.</p> <p>3. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including traumatic subdural hemorrhage, diabetes, malnutrition, and respiratory failure.</p> <p>On 7/24/24 at 9:36 AM, observed CNA #2 provide Resident #41 with foley catheter care. CNA #2 donned gloves and cleaned Resident #41's urinary meatus (the opening in the penis where the urine comes out) and then cleaned a small amount of stool from his rectum. CNA #2 did not change soiled gloves before placing a clean brief on Resident #41.</p> <p>On 7/24/24 at 9:38 AM, observed CNA #2 donning a new pair of gloves without performing hand hygiene, to drain Resident #41's foley drainage bag.</p> <p>On 7/24/24 at 9:43 AM, CNA #2 stated she should have changed her gloves after providing catheter care to Resident #41 and she did not know she needed to wash her hands when changing her gloves.</p> <p>4. Resident #49 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and COPD.</p> <p>On 7/24/24 at 11:34 AM, LPN #2 used the glucometer (a device used to measure the amount of glucose in your blood) to check Resident #49's blood sugar. LPN #2 brought the glucometer to the medication cart and was observed wiping the glucometer off with a Sani-cloth (disinfecting wipe) and then placed the glucometer on a tissue, on top of the medication cart. LPN #2 did not follow recommended dry time of 2 minutes as listed on the Sani-cloth container.</p> <p>On 7/24/24 at 11:39 AM, LPN #2 removed Resident #49's insulin pen from the top drawer of the medication cart. She then placed the needle on the tip of the insulin pen. LPN #2 did not clean rubber cap of the insulin pen prior to applying the needle.</p> <p>On 7/24/24 at 11: 43 AM, LPN #2 stated the needle was still covered so she did not think she had to clean the insulin pen stopper. She also stated she thought the dry time for the Sani-cloth was 2 minutes, but she would have to check, and she did not know it had to be kept wet for the 2 minutes.</p> <p>Resident #10 was admitted to the facility on [DATE], with multiple diagnoses including diabetes and hypertension.</p> <p>(continued on next page)</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  07/26/2024
NAME OF PROVIDER OR SUPPLIER  Monte Vista Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1071 Renee Avenue Pocatello, ID 83201	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/24/24 at 11:49 AM, LPN #1 used the glucometer to check Resident #10's blood sugar. LPN #1 brought the glucometer to the medication cart and was observed wiping the glucometer off with a Sani-cloth and then placed the glucometer on a tissue, on top of the medication cart. LPN #1 did not follow recommended dry time of 2 minutes as listed on the Sani-cloth container.</p> <p>On 7/24/24 at 11:57 AM, LPN #1 stated the dry time for the Sani-cloth was 2 minutes, but she did not realize it had to stay on the glucometer for 2 minutes.</p> <p>On 7/26/24 at 8:50 AM, the DON stated the facility did not have an Insulin pen use/cleaning policy. They just follow the regular insulin policy.</p> <p>50983</p> <p>The facility's Oxygen Use policy with a revision/review dated January 2024, documented the filter on the concentrator should be checked at least every month and cleaned as needed.</p> <p>Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including cerebral palsy, chronic respiratory failure, and diabetes.</p> <p>Resident #14's physician order documented to change tubing, clean filter, and change oxygen water bottle every Sunday on the night shift, starting 12/19/21.</p> <p>On 7/22/24 at 11:22 AM, surveyor observed the filter on Resident #14's oxygen concentrator to have a thick layer of dust.</p> <p>On 7/26/24 at 8:48 AM, the IP stated the night shift nurse is responsible for cleaning the filters on the side of the oxygen concentrators. Additionally, the IP stated the oxygen concentrators should be cleaned monthly and PRN.</p>