



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

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3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

FILE COPY

February 20, 2015

Monica K. Brutsman, Administrator  
Trinity Mission Health & Rehab of Holly, LLC  
2105 12th Avenue Road  
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On **February 5, 2015**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LLC by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual 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 and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page.2). **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. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 5, 2015**. Failure to submit an acceptable PoC by **March 5, 2015**, may result in the imposition of civil monetary penalties by **March 25, 2015**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **March 12, 2015 (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 **March 12, 2015**. A change in the seriousness of the deficiencies on **March 12, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 12, 2015** includes the following:

Denial of payment for new admissions effective **May 5, 2015**. [42 CFR §488.417(a)]

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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 **August 5, 2015**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 5, 2015** 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 noncompliance 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

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2001-10 IDR Request Form

This request must be received by **March 5, 2015**. If your request for informal dispute resolution is received after **March 5, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink that reads "D.J. Scott". The signature is written in a cursive style with a large, stylized "S" at the end.

DAVID J. SCOTT, R.N., Supervisor  
Long Term Care

DJS/dmj  
Enclosures

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

PRINTED: 02/19/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/05/2015
NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The following deficiencies were cited during the complaint survey of your facility.  The surveyors conducting the survey were: ---Lauren Hoard, RN BSN - Team Coordinator Arnold Rosling, RN QMRP  The survey team entered the facility 2/4/15 and exited on 2/5/15.  Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CM = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed	F 000	Preparation and submission of this plan of correction by, Trinity Mission Health & Rehab of Holly LLC, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.  RECEIVED MAR - 5 2015 FACILITY STANDARDS  F153  Specific Resident  1. On 2/12/15 Medical Records contacted the legal representative of Resident # 2 by phone to identify if there were any additional copies of the medical records that were needed and there were none requested. The root cause was determined that the legal representative wanted additional information than was initially requested.  Other Residents  2. On 3/2/15 the Administrator reviewed the request of Medical Records for the past 90 days and followed up with the party requesting the Medical Record to ensure that requested Medical Records were received and concerns were addressed at that time.	
F 153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS  The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.	F 153		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mon B St* TITLE Administrator (X6) DATE 3-3-15

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

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F 153	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to provide a resident's guardian with the medical records they were seeking. This was true for 1 of 1 (#2) sampled resident. There was potential for psychological harm when residents do not receive copies of their own medical records they have requested. Findings include:</p> <p>Resident #2 was admitted to the facility on 12/30/14, and readmitted on 1/6/15 and on 1/27/15. The resident's diagnoses included quadriplegia, post fractures of multiple cervical vertebrae and acute and chronic respiratory failure.</p> <p>A family member of Resident #2, who was named the resident's guardian, requested copies of the resident's medical record on 1/22/15 for the period of 1/6/15 through 1/2015. The facility gave the family member a form to complete that had boxes to check for the specific notes requested. The form did not include an area for the family member to request the resident's Respiratory Therapist reports, nor was there a place on the form to check for the family member to request everything in the resident's record between the specific dates. The form did include an area marked "other," where the resident's entire record could be requested, however the form did not include instruction explaining how the form should be filled out for an entire medical record and Resident #2's guardian did not receive the records the family wanted to review.</p> <p>The medical record staff member was interviewed 2/4/15 at 3:00 p.m. on the process for</p>	F 153	<p><b>Systemic Changes</b></p> <p>3. The Authorization Form for the Release of Health Information was revised to include; All Medical Records, Respiratory Notes along with an additional line for "other" as an option for choices of the Medical Record request on 3/4/15 and department managers were educated on the revised form by the Director of Nursing. Medical Records will document verbal requests for records on the Authorization Form for the Release of Health Information. A log will be kept in Medical Records that will track when records requests are made, which records, by whom, and date released to ensure that the requested Medical Records are received in a timely manner as required.</p> <p>On 2/09/15 the facility staff were educated on the procedure for residents or legal representative requesting medical records, and that verbal requests may be made, of the specific medical records by documenting the request onto the Authorization Form for the Release of Health Information to ensure that the requested information will be received from Medical Records.</p>		

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F 153	Continued From page 2 families to request and receive copies of records. The medical record staff member stated the resident or family must submit the request in writing. After the facility received the request, then the form, resident face sheet, and power of attorney must be faxed to the facility's corporate attorneys for approval. Once approval is procured, the medical record staff receive an e-mail to copy the specific contents requested. The facility does not charge for copies of resident medical records, he stated.  The DON and Administrator were informed of the issue on 2/5/15 at 2:45 p.m. No further information was provided.	F 153	<b>Monitoring</b>  4. Beginning the week of 3/05/15 the Administrator or designee will audit requests for medical records weekly for 4 weeks, then every 2 weeks for 4 weeks, then monthly for 3 months and quarterly thereafter to ensure that verbal and written requests of Medical Records are being honored and complete copies provided timely to the resident or legal representative as required. A report will be submitted to the Quality Assurance Performance Improvement committee for three months. The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Administrator is responsible for monitoring and follow-up.  Date of Compliance 3/5/15		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, it was determined the facility failed to identify weight loss trends and failed to implement interventions in a timely manner after the resident's weight loss became significant. This	F 325	<b>Specific Resident</b>  1. On 2/09/15, the Director of Nursing (DON) reassessed Resident # 1 for concerns related to weight loss, the resident's weight remains above her ideal body weight, and no concerns were noted. On 2/13/15 a root		

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F 325	<p>Continued From page 3</p> <p>failed practice harmed 1 of 6 (#1) sampled residents. The resident was harmed when she experienced severe weight loss of 15% in 14 days. Additionally, this failed practice had the potential to harm any resident who experienced a compromised nutritional status. Findings included:</p> <p>Resident #1 was admitted to the facility on 6/4/14 with multiple diagnoses which included acute and chronic respiratory failure, pneumonia and diabetes.</p> <p>The admission MDS assessment, dated 6/11/14, documented Resident #1 was cognitively intact with a BIMS of 14, had a depression severity score of 14, did not display behaviors, required supervision after setup for eating, weighed 189 pounds with no weight loss or gain of 5% or more in the preceding month or a loss of 10% or more in the preceding 6 months and did not receive diuretic medications.</p> <p>The quarterly MDS assessment, dated 11/10/14, documented Resident #1 did not display behaviors, required limited assistance of 1 person for eating, weighed 163 pounds with no weight loss or gain, and did not receive diuretic medications.</p> <p>The June 2014 Resident ADL Record documented Resident #1 ate 25% of meals 18 times, 50% of meals 27 times, 75% of meals 8 times, 100% of meals 9 times, and refused meals 5 times. There were 8 meals not documented.</p> <p>The July 2014 Resident ADL Record documented Resident #1 ate 25% of meals 48 times, 50% of meals 10 times, 75% of meals 1 time, 100% of</p>	F 325	<p>cause analysis was completed by the IDT to determine why resident # 1 had weight loss that was not identified timely. It was determined that the shower aides when weighing the resident were not reporting weight changes to the Licensed Nurse, for timely interventions and notification to the physician. In addition it was identified that the Registered Dietician was not reviewing the most current weight during her assessments, which caused a gap in interventions.</p> <p><b>Other Residents</b></p> <p>2. On 2/11/15 the Director of Nursing completed an audit of facility resident's previous weight to the resident's current weight to identify significant unplanned weight loss or gain, and there were no concerns noted.</p> <p><b>Systemic Changes</b></p> <p>3. The internal process for monitoring weight was revised. The C.N.A.s will notify the licensed nurses of weight changes. The licensed nurse will witness a re-weight and verify the weight change. The licensed nurse will sign off on the weight and communicate via the 24 hour report as necessary for timely follow-up and interventions. The DON will review weights</p>	

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F 325	<p>Continued From page 4</p> <p>meals 5 times, and refused meals 25 times. There were 3 meals not documented and one meal involved a family party.</p> <p>The following information was gathered from the Dietary Care Plan (CP), Yearly Weight Record (YWR), Comprehensive Nutritional Assessment (CNA), Nutrition Services Progress Note (NSPN), Physician Progress Notes (PPN) and Nurse's Notes (NN):</p> <p>6/4/14 (YWR) - 185.8 lbs (pounds); 6/4/14 (CP) - Provide regular diet per MD order, honor likes and dislikes, weekly weights, Registered Dietitian (RD) to follow PRN (as needed), resident eats in room per her choice, resident is making independent food choices, and resident is independent with eating; 6/9/14 (PPN) - Visit for hypoglycemia, anxiety and hyperlipidemia with no mention of weight loss concerns; 6/11/14 (YWR) - 189.2 lbs (3.4 lb gain); 6/12/14 (PPN) - Visit for iron anemia, hyperlipidemia and Vitamin D deficiency with no mention of weight loss concerns; 6/13/14 (Admission Evaluation CNA) - Admit weight 185.8 (Weight taken on 6/5/14). Evaluation &amp; Summary: Resident independent with eating and making food choices. Feeds self in room due to isolation. Increased BMI (Body Mass Index) 33. Slow gradual weight loss would be desirable. Last labs with decreased iron, hemoglobin and hematocrit. Resident on supplements to help improve. Skin intact. Recommendations &amp; Plan: Continue with plan of care. Monitor weight and notify RD with significant change. Review PRN; 6/18/14 (YWR) - 179.2 lbs (10 lb loss); 6/18/14 (PPN) - Visit for bipolar disorder, urinary retention, diabetes, iron anemia and Vitamin D</p>	F 325	<p>weekly for trends and changes. The DON or designee will notify the physician and Registered Dietitian of weight trends and changes for timely interventions, and if a resident voices a desire for a planned weight loss for physician involvement.</p> <p>On 2/6/15, the Nursing Staff were re-educated by the Staff Development Coordinator, related to revision of internal process for identifying weight loss, and reporting weight fluctuations timely. On 2/6/15, the interdisciplinary team (IDT) was re-educated on reporting identified weight loss timely to initiate and implement dietary interventions.</p> <p><b>Monitoring</b></p> <p>4. Beginning the week of 3/5/15, the Unit Manager or designee will complete audits of 5 resident weights weekly for 4 weeks, then every 2 weeks for 4 weeks, then monthly for 3 months and quarterly thereafter to ensure that resident change in weights are being reported timely, timely RD assessment are completed, interventions, and physician is notified as indicated. A report will be submitted to the Quality Assurance Performance Improvement committee for three months.</p>	

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F 325	Continued From page 5 deficiency with no mention of weight loss concerns; 6/20/14 (CNA) - Weight 189.2, taken on 6/11/14. Evaluation & Summary: Resident feeds self and is independent with making food choices. Increased BMI. Slow gradual weight loss would be desirable. Intakes fair between 25-50% most meals and inadequate for fluids. Offer increased fluids with and between meals. Last labs 6/12 with decreased hemoglobin and hematocrit, on supplement. Meds with nutrition interactions. Skin intact. Recommendations & Plan: Start NCS (No Concentrated Sweets) diet related to diabetes mellitus. Monitor weight. Notify RD with significant change. Review PRN; 6/20/14 (PPN) - Visit for urinary retention with no mention of weight loss concerns; 6/25/14 (YWR) - 160 lbs (19.2 lb loss, with a total of 29.2 lbs since admit); 6/26/14 (NSPN) - Weight 179.2, taken on 6/18. Resident weight down 10 pounds from previous weight. Resident still with increased BMI. Family also brings in food. New labs 6/17. Resident is on iron supplement and simvastatin for cholesterol. Continue with plan of care at this time. If weight decreases significantly again will implement interventions to slow. Gradual weight loss desirable; 6/26/14 (CP) - NCS diet; 6/29/14 (YWR) - 156.8 lbs (3.2 lb loss, with a total of 32.4 lbs since admit); 7/1/14 (NSPN) - Weight 160, taken on 6/25/14. Resident weight down 9 pounds (Weight down 19.2 pounds, not 9 pounds) this week. Intakes not adequate. No new labs. No new meds. Recommend to start nutritionally enhanced meals until intakes improve. RD attempted to meet with resident but was sleeping, will attempt again. RD to continue to monitor weight loss;	F 325	The Quality Assurance Performance Improvement committee will review and determine if further interventions are needed at that time. The Director of Nursing is responsible for monitoring and follow-up.  Date of compliance 3/5/15		

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F 325	<p>Continued From page 6</p> <p>7/1/14 (CP) - Nutritionally Enhanced Meals;</p> <p>7/2/14 (PPN) - Visit for dysphagia, anxiety bipolar and diabetes with no mention of weight loss concerns;</p> <p>7/7/14 (PPN) - Visit for weight loss. "[Resident's name] tells me she doesn't 'like' the food here. Family does bring in some food. Will have nutrition see her to see if they can meet her preferences. She has lost ~29lbs since her admission here."</p> <p>7/9/14 (YWR) - 147.4 lbs (9.4 lb loss, with a total of 41.8 lbs since admit);</p> <p>7/10/14 (NSPN) - Weight 156.8, taken on 6/29. Resident weight down 3 pounds this week. Resident with multiple refusals. RD was notified that husband is eating food. Family still providing some foods from home. No new labs. 7/9 buspar decreased. Recommend to start increased kcal with poor appetite at meals. Send FFL (Full Fortified Liquids) three times per day with all meals to help improve kcals and fluids. Weight stabilization desirable. Will continue to monitor. Continue to encourage. Resident with some confusion, may need increased assistance at meals;</p> <p>7/10/14 (CP) - FFL three times per day with all meals and increase kcal snacks three times per day;</p> <p>7/18/14 (NSPN) - Weight 147.4, taken on 7/9. Resident weight down 9 pounds this week. All previous recommendations started. Resident now with UTI and increased confusion, started on antibiotics. New labs 7/10. MD aware of weight loss. Discussed interventions in place. RD will be coming in 6/20 to meet with family about weight loss, interventions and possibly artificial nutrition. Intakes could continue to improve as UTI clears. Send sherbet all meals. Will implement further interventions after discussion with family. Add to</p>	F 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 7 NRR in next week; 7/18/14 (CP) - Sherbet all meals; 7/19/14 (YWR) - 147.2 lbs 7/20/14 (NSPN) - RD met with family to discuss weight loss and any further interventions that may be effective to slow. Family aware of weight loss. Resident was alert but confused. Family had also brought in some food. Family states she might need increased encouragement with meals. Will notify nursing. Resident and family state at this time she is doing better with things she can drink. Send whole milk all meals. Resident states she continues to have a poor appetite. Will discuss with MD possibility of an appetite stimulant. Family is filling out menu states she is a picky eater. Dietary Manager to reobtain preferences. Resident BGs (blood sugars) fairly low and recommend to discontinue NCS portion to liberalize to help improve intakes. family providing nondiabetic foods. Send increased kcal desserts in place of fruit. RD also discussed artificial nutrition with family if weight loss continues. Family and resident state they would like that to happen if weight loss continues so rapidly; 7/20/14 (CP) - Send whole milk all meals and increase kcal desserts in place of fruit; 7/21/14 (NSPN) - IDT reviewing resident related to weight loss. Weight on 7/19 was 147.2 lbs. Resident weight stabilized this week. RD discussed newest recommendations. Will receive order. Also to request clarification order for interventions in place. Nursing to assess isolation now that antibiotics ending today. Resident might do well in assist dining room. Resident on multiple meds with increased appetite and increased weight side effects. Will wait on appetite stimulant at this time. Weight stabilization desirable. IDT will follow resident weekly. Will continue with by mouth interventions	F 325		

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

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F 325	<p>Continued From page 8</p> <p>at this time. If significant weight loss continues to occur will readdress artificial nutrition. Review in 1 week;</p> <p>7/22/14 (NSPN) - Nursing requesting to change supplement with med pass to 2 cal. With recent weight loss this is appropriate. Discontinue FFL or equivalent four times per day with med pass. Change order to 2 cal 120 cc with med pass. Continue to follow. Review prn;</p> <p>7/24/14 (CP) - Start 4 ounces (oz) 2cal with med pass, now on regular diet;</p> <p>7/30/13 (NSPN) - Weight 145.8, taken on 7/30. Resident weight down 1 pound this week. Weight loss slowed. Resident received order for discontinuing NCS diet. Resident was also started on Remeron 7/22 for depression. side effects of increased weight and increased appetite. Intakes have improved. Dietary manager reinterviewed for preferences. New labs 7/23. Resident could benefit from 1-2 oz of extra protein with meal to help with depleted protein stores. Multiple interventions in place for weight loss. Weight stabilization desirable;</p> <p>7/30/14 (CP) - Will increase protein intake with meals, extra protein (1-2 oz) with each meal.</p> <p>On 2/4/15 at 9:03 AM, Resident #1 was interviewed and said when she was admitted she did not have an appetite and was not eating.</p> <p>On 2/4/15 at 12:40 PM, the DON was asked which interventions were added when Resident #1 lost 10 lbs in 1 week. She said on 7/1 - 7/10/14 nutritionally enhanced meals, FFL three times per day, sherbet at all meals, and higher kcal snacks three times per day were the first interventions she could see in the resident's record. The DON said the resident was refusing meals because she was very depressed when</p>	F 325		

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F 325	<p>Continued From page 9</p> <p>she was first admitted, was unable to get out of bed due to the ventilator and her husband was not visiting enough. The only physician notification the DON could find regarding weight loss was in October 2014, four months after Resident #1's admission to the facility, but she would look into it further. The DON said the desired gradual weight loss was part of the resident's personal plan, but the physician would not be involved unless the resident triggered for 5% or 10% weight change.</p> <p>On 2/4/15 at 2:50 PM, the RD was interviewed via phone and said, "We hadn't added any interventions" after Resident #1 lost 10 lbs. The resident initially gained 3.4 lbs and the 10 lb loss was not compared to the admission weight; and staff were trying to get a baseline. She explained when the resident lost 10 lbs, the percentage of loss did not change much from the 3.4%, which was under 5%. The following week, when the resident had a significant drop in weight, the RD was notified and requested a reweigh, which was accurate in regards to the 19.2 lb weight loss. A fortified meal program was started on 7/1/14, after the weight fluctuations. When asked about the process for RD notification of significant weight changes, the RD said usually the nurses would be notified and would then report the information to the RD, who would then address the concerns on her next working day (worked on Tuesdays and Fridays). The RD said she was not sure what caused the initial weight gain as the resident was not on any diuretics and did not have edema. Weights tended to fluctuate while the resident was on the ventilator unit, the resident was not eating much in general, and the husband was eating the resident's left over food. When asked about physician involvement with</p>	F 325		

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F 325	<p>Continued From page 10</p> <p>the gradual weight loss desired, as documented in the Comprehensive Nutrition Assessment, the RD said if the BMI was high, they work towards the personal goal of the resident, and gradual weight loss could be beneficial. The RD was asked if there was an order for gradual weight loss and she said, "In this case, no. There was no order for it."</p> <p>On 2/5/15 at 1:00 PM, the RD was asked about the time gap between weights and her notes/assessments (8-9 day difference). She explained the staff usually weighed residents on shower days. The Nurse Manager on Fridays would put the weights together from the shower book and give the report to the DON. The DON would put together her reports and notify the physician and RD. The RD and DON would review the reports together to determine a plan. The RD and DON also did some education with the Dietary Manager (DM) to start interventions and notify the RD of those interventions. If the shower day was on Monday, the weights would not be reviewed until Friday. The RD said she did not know if the DM was notified of the weight changes for Resident #1. The resident initially gained 3.4% and was started on a diabetic diet in which the resident was not compliant. The RD stated she was looking at the "full picture" with weight fluctuations. The RD explained the NEM and FFL provided an extra 200-300 calories. When asked about the DM's credentials, the RD said the DM took an online course and the DM was not sure of that course's educational parameters; better for her to be cautious than overstep.</p> <p>On 2/5/15 at 1:20 PM, the policy and procedure related to weights was requested. At 2:23 PM, the</p>	F 325		

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F 325	<p>Continued From page 11</p> <p>DON she said the facility did not have a formal policy related to weighing, but an internal process was written and provided to surveyors.</p> <p>The Internal Process, no date provided, documented, "There is no Policy for weighing resident's [sic] or reporting just our internal procedure. Weights are done weekly (unless res[ident] requests otherwise or they are CMO [term unknown]). Shower aides do all weights with their shower and record in weight book[.] Unit manager gathers weights on Fridays and makes the weight lists[.] Unit managers record weights in chart and DNS records weight in computer. Weight list is given to RD/DM weekly[.] RD/DNS print weight loss comparison report weekly to identify weight changes. NAR [Nutrition At Risk] is held weekly. RD is in building twice weekly."</p> <p>Resident #1 was admitted on 6/4/14 with a weight of 185.8 lbs and gained 3.4 lbs in the first week. The second week, the resident lost 10 lbs (9.4% of body weight) and no interventions were put into place at that time to prevent further weight loss. The third week, the resident lost another 19.2 lbs (15.4% of body weight) and nutritionally enhanced meals were implemented. The resident lost more than 15% of her body weight in 14 days. The physician or NP did not order a gradual weight loss plan, nor were they notified of the severe weight loss until 7/7/14 (two weeks after 29.2 lbs were lost). Additionally, there were time gaps between weights and the RD assessments of 8 to 9 days, and the DM did not intervene with timely planning and interventions.</p> <p>On 2/5/15 the Administrator provided a QA (Quality Assurance) document, dated September 2014, which documented, "It has been discovered</p>	F 325		

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F 325	Continued From page 12 that the RD assessments in the dietary sections of the charts have not been done timely and are out of compliance. The DM had not been trained in completing these, and the RD that rounds weekly was not able to do all admits, quarterly's and annuals. Not all of the high risk charts have been followed closely, also not all new admits or wound pts [patients] have been seen timely. NAR/PAR [Nutrition At Risk/unknown] was not at a set time or date and no lists were being made of resident's [sic] being reviewed..."  On 2/5/15 at 3:30 PM, the Administrator and DON were informed of the significant weight loss issues. No further information was provided.  On 2/6/15 additional information was provided by the facility, however, it did not resolve the issue.	F 325			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/05/2015
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NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF HOLL	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 284	<p>02.107,03,a General Diets</p> <p>03. General Diets.</p> <p>a. The general menu shall provide for the food and nutritional needs of the patient/resident in accordance with the Recommended Daily Allowances of the Food and Nutritional Board of the National Research Council. A daily guide for adults shall be based on the following allowances: This Rule is not met as evidenced by: Refer to F325 as it relates to weight loss.</p>	C 284	See F-325	
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RECEIVED  
MAR - 5 2015  
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mon [Signature]</i>	TITLE Administrator	(X6) DATE 3-3-15
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IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- Director

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

PHILIP COPY

April 6, 2015

Monica K. Brutsman, Administrator  
Trinity Mission Health & Rehab of Holly, LLC  
2105 12th Avenue Road  
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On **February 5, 2015**, an unannounced on-site complaint survey was conducted at Trinity Mission Health & Rehab of Holly, LLC. The complaint allegations findings and conclusions are as follows:

**Complaint #6399**

**ALLEGATION:**

The complaint stated that sometime in January or February 2014, staff charted that a resident (A) was verbally abusive to other residents. The Director of Nursing (DoN) told the writer to rewrite the nurses' note without the mention of resident abuse.

In addition, the complainant identified that on March 5, 2014, a second resident (B) was found in the facility's parking lot. The facility did not report this incident to the State Survey Agency (SSA).

**FINDINGS:**

During the investigation, the resident and the staff member were identified by the surveyors. The medical record progress notes for Resident A during both January and February 2014 were

Monica K. Brutsman, Administrator  
April 6, 2015  
Page 2 of 2

reviewed. The staff member's documentation was never found in a location where they would be the only person to rewrite their notes. The staff member's notes were found in the middle or at the end of a page. There was a documentation of the resident being verbal during the super bowl game but no other documentation was found that would appear to be verbal abuse to other residents.

The DoN was interviewed on February 4, 2015, at 12:40 p. m. The DoN was asked if she had ever asked a staff member to change their documentation. She said she had not. She further stated that if there were a disagreement between her and her staff on documentation she would also make a nurses' note with a clarification but would never ask anyone to change documentation.

The facility's Incident Report dated March 1, 2014, documented a resident (B) was found outside the facility by a night shift who was coming into the building 9:30 p.m. The resident, who had intact cognition, was noted to be alert and oriented, although a little confused and was ambulating, "per usual." Staff interviewed at the time of the survey confirmed what was in the report and stated that because of the resident's cognition level, the facility did not view it as an elopement. There was no indication the incident needed to be reported to the SSA.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor  
Long Term Care

NS/dmj



IDAHO DEPARTMENT OF  
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3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0099  
PHONE 208-334-6626  
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FILE COPY

March 23, 2015

Monica K. Brutsman, Administrator  
Trinity Mission Health & Rehab of Holly, LLC  
2105 12th Avenue Road  
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On **February 5, 2015**, an unannounced on-site complaint survey was conducted at Trinity Mission Health & Rehab of Holly, LLC.

During the complaint investigation, the following documentation was reviewed:

- The records of six residents including that of the identified resident,
- Incident and Accident reports from June 2014 to February 2015,
- Grievances from June 2014 to February 2015,
- Resident Council Meeting minutes from June 2014 to February 2015, and
- Abuse Investigations from June 2014 to February 2015.

Interviews were conducted with the facility's Administrator, Director of Nursing (DoN),  
~~Registered Dietician (RD) and one resident.~~

Throughout the investigation, observations were made of the call light response time.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6607**

ALLEGATION #1:

The complainant stated an identified resident was admitted to the facility with pressure sores on the buttocks, but the sores had gotten worse because the facility did not provide any treatment.

FINDINGS #1:

The identified resident's medical record was reviewed and provided evidence that the resident was admitted without pressure ulcers and had an order for barrier cream to the buttocks two times per day and as needed. The medical record provided evidence that the barrier cream was applied per physician's orders.

Interviews with the DoN and wound nurse confirmed the identified resident was admitted without pressure ulcers and did not acquire pressure ulcers after admission to the facility.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated an identified resident was using briefs for incontinence and was found wet on several occasions.

FINDINGS #2:

The identified resident's medical record was reviewed and provided evidence that the resident was admitted with a Foley catheter, which was removed June 19, 2014. The resident utilized a bedpan and attends afterwards and was offered the bedpan to toilet every hour. It was documented that the resident would voice the need to use the bedpan and the resident's attends would already be wet.

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The identified resident was interviewed and did not have any concerns related to receiving assistance for bladder and bowel needs.

Based on records review and resident interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated call lights were not answered for 20-25 minutes, and that staff turns off the call light and tell the residents they will be back later to help. The residents then have to wait 10-15 more minutes before they are assisted.

FINDINGS #3:

Observations were conducted to determine how facility staff responded to call lights. Staff answered call lights in five minutes to less.

Grievances were reviewed and provided evidence that there were no concerns related to call light response time.

The identified resident was interviewed and reported no concerns with call light response times. The resident said if there was something going on and staff were unable to assist at that moment, they would provide an explanation for the wait and return as soon as they were able, which was not a problem for the resident.

Based on observations, records review and resident interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident lost 60-70 pounds in the first few months of living in the facility because staff were not assisting as needed.

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FINDINGS #4:

The identified resident's medical record was reviewed and provided evidence that the resident initially gained approximately three pounds in the first week of admission to the facility, lost ten pounds the second week and lost 19.2 pounds the third week before interventions were put into place to prevent further weight loss.

Monica K. Brutsman, Administrator  
March 23, 2015  
Page 4 of 5

Based on records review and interviews with the RD, DoN, Administrator and an identified resident, the facility was cited at F325 for non-compliance related to weight loss.

**CONCLUSIONS:**

Substantiated. Federal and State deficiencies related to the allegation are cited.

**ALLEGATION #5:**

The complainant stated visiting hours were limited because visitors were assisting to get an identified resident up without staff present and touching ventilator equipment.

**FINDINGS #5:**

The identified resident's medical record was reviewed and provided evidence of Social Services, Administration, Nursing, the Ombudsman and Respiratory Therapy involvement related to concerns with ventilator equipment/settings, assisting the resident with transfers without staff present and smoking on the vent unit. A meeting was held with the above in attendance, including family members, in which a plan was developed to ensure resident's safety while respecting resident's rights. Visiting parameters were set and all parties agreed to the arrangement.

The identified resident said there was an issue with visitors at one point but it had been resolved and there were no further concerns.

Based on records review and staff and resident interviews, it was determined the allegation could not be substantiated with deficient practice.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #6:**

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The complainant stated an identified resident was confused on several occasions.

**FINDINGS #6:**

The identified resident's medical record was reviewed and provided evidence that the resident's cognition was intact. The resident did have increased confusion related to a urinary tract infection in July 2014. The confusion cleared when the urinary tract infection resolved.

Monica K. Brutsman, Administrator  
March 23, 2015  
Page 5 of 5

Based on records review, it was determined the allegation could not be substantiated.

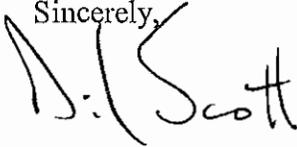
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj

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IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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FILE COPY

March 23, 2015

Monica K. Brutsman, Administrator  
Trinity Mission Health & Rehab of Holly, LLC  
2105 12th Avenue Road  
Nampa, ID 83686-6312

Provider #: 135094

Dear Ms. Brutsman:

On **February 5, 2015**, an unannounced on-site complaint survey was conducted at Trinity Mission Health & Rehab of Holly, LLC.

The complaint was investigated on February 4, 2015 and February 5, 2015. The resident's nursing home and hospital medical records were reviewed.

Interviews were conducted with the following:

- Nurse Practitioner (NP);
- Director of Nursing (DoN);
- Social Service;
- RN on duty the night of the incident;
- Two LPNs;
- Two residents;
- Respiratory Therapy Supervisor;
- Respiratory Therapist; and
- Medical Records Supervisor

The following documentation was reviewed:

- Medical records of two residents;

- Policy and Procedures for Catheterization and Medical Record Requests; and
- Student Services Agreement

The complaint allegations, findings and conclusions are as follows:

### **Complaint #6845**

#### **ALLEGATION #1:**

Resident presented with dark amber urine in Foley collection bag and was taken "unresponsive" to St. Alphonsus Medical Center (unknown mode of transportation), where he was admitted with "sepsis" on January 20, 2015.

#### **FINDINGS #1:**

The survey team was not able to substantiate the facility was not in compliance with the regulations. The findings of the team were:

The resident was admitted to the facility on December 31, 2014. On January 1, 2015, the resident started to have breathing problems and was admitted to the local hospital. The emergency room physician documented diagnoses of "Acute on chronic respiratory failure; Pneumonia, healthcare associated and possible aspiration; Sepsis and Lactic Acidosis." The resident was placed on antibiotics, ventilator and chest physiotherapy.

The resident was seen during this hospitalization by a pulmonologist, and a bronchoscopy was performed on January 2, 2015. The pulmonologist diagnoses were left lower lobe atelectasis and possible pneumonia.

On January 3, 2015, the resident's physician documented the admission was the third in three months, and he also diagnosed the resident with acute on chronic respiratory failure, pneumonia, healthcare associated and possible aspiration with lactic acidosis. The resident improved and was discharged back to the nursing home on January 6, 2015.

The resident resided on the ventilator unit at the facility. The resident would be off the ventilator during the day but required it at night. The resident's vital signs and ventilator operations were monitored and documented daily by the respiratory therapist.

On January 7, 2015, the resident was seen in the nursing home by his physician. The physician documented that the resident had "left sided pneumonia." He was still receiving Levaquin, which the physician continued.

On January 9, 2015, the resident was seen in the nursing home by the nurse practitioner (NP) for "shortness of breath" and "anxiety state." The NP documented, "Will place him on low-dose Ativan when necessary."

On January 12, 2015, the resident was seen again in the nursing home by the NP. The visit was a follow-up visit based on the results obtained from a sputum culture. The assessment documented "Pneumonia, Organism. His sputum culture and sensitivity shows Pseudomonas that is sensitive to the Levaquin he is on."

On January 12, 2015, at 11:00 a.m. a nursing note documented, "New/order: Jevity 1.5, 70 milliliters per hour times 24 hours, Fluid flush 200 cc every 4 hours."

On January 16, 2015, at 11:00 a.m. a nursing note documented, "...completed course of Levaquin for PNA (Pneumonia)..."

On January 20, 2015, at 1:55 p.m. a Registered Nurse (RN) documented the resident's vital signs were stable and the resident was alert and able to make needs known. There was no documentation about the urine output or color.

The afternoon shift vital signs taken by the CNAs on January 20, 2015, documented: temperature 97 degrees Fahrenheit, pulse 102, respirations 16 and blood pressure of 128/72. On January 20, 2015 at 7:00 p.m., a different RN documented that a certified nurse aide (CNA) notified her there was leaking around the catheter. The RN attempted to flush the catheter but it was "plugged." The RN had a student nurse with her that night. The documentation indicated the student changed the catheter. The nursing documentation and the interview conducted on February 4, 2015 at 2:30 p.m., with the RN revealed the proper sterile procedure was used to complete the catheter change. The RN indicated staff did not get a good return from the catheter. The Nurse Practitioner was interviewed on February 5, 2015 at 2:10 p.m. and he indicated it was not unusual to replace a catheter and not get a return back of urine.

The Medication Administration Record documented the resident received Ativan 1 milligram orally at 8:00 p.m. There was no documentation for why the medication was given but it was ordered for "anxiety and shortness of breath."

The RN was still concerned with the lack of urinary return after twenty minutes. At 7:30 p.m., another nurse catheterized the resident with a Caude catheter and received 200 cc blood-colored urine. The NP was contacted and ordered the resident's heparin to be held for 24 hours. The resident remained alert and oriented during the procedure. The nurses' notes documented the resident complained of neck and leg pain.

The Respiratory Therapist documented on January 20, 2015 at 8:00 p.m., "RN's and CNA's

working with the resident for last 20 to 30 minutes on Foley catheter. Upon assessment, Resident found in some mild respiratory and obvious discomfort with HR (heart rate) > (greater than) 150. RN notified..." At 9:00 p.m., the therapist documented, "Resident noted HR 130, and in some discomfort..." At 9:45 p.m., the therapist documented, "HR > 130, SPO2 >97% (Oxygen Saturation) with oxygen two liters per minute via nasal cannula, BP 90/35, unresponsive to sternal rub..."

The nursing notes documented on January 20, 2015 at 10:00 p.m., that a CNA notified the RN that the resident was unresponsive. The resident's vitals were pulse 128 and blood pressure was 98/38. The resident would not respond to sternal rub. The resident was transported by ambulance to the emergency room.

The resident was admitted to the hospital on January 21, 2015. The history and physical documented 12 different issues under "Assessment and Plan." The significant issues included: "1. Septic shock secondary to urinary tract infection and probable bacteria pneumonia... 2. Hypotension. This is most likely secondary to sepsis... 4. Lactic acidosis. This is related to sepsis... 5. Altered mental status. This is likely related to Ativan that was given to the patient at 8pm at the nursing home..."

The urine culture grew Proteus Mirabilis. The resident was treated with antibiotics and was discharged back to the nursing home on January 27, 2015.

Allegation #1 could not be substantiated for deficient practice. The resident had chronic respiratory problems, chronic pneumonias, frequent urinary tract infections and several episodes of sepsis with hospitalizations.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated he spoke to a respiratory therapist about concerns he had with the identified resident. The complainant stated he told a respiratory therapist and administrator, that disorientation and memory impairment usually signaled infection for the identified resident. He was told by the respiratory "supervisor" that "he didn't have time to deal with" these concerns; the administrator reportedly told the complainant that the identified resident was a new resident to the facility and "would have to get used to how things are done" in the facility.

#### FINDINGS #2:

The respiratory therapy supervisor was interviewed February 4, 2015, at 1:50 p.m. When asked

how he coordinated the resident's care and the input from families, he said he listened to family suggestions and their input. He further indicated that sometimes families want things done immediately and stated his priorities were the safety and care of the respiratory status of the residents. Sometimes families interpret any delay as not listening, but in fact, the safety of the resident is the priority, he noted.

The ventilator and alarm thresholds were based on the admission assessments. The therapist review the ventilator information each time they are in the room and document their findings in the logbook. There are certain items that are required to be completed and documented.

The Director of Nursing and Social Worker were interviewed February 5, 2015 at 12:30 p.m., and stated there was a family meeting on January 9, 2015, in which the family was encouraged to provide information at the meeting. The Social Worker indicated there had been several meetings since, including one on February 5, 2015. She was working on setting up a meeting with the physician managing the ventilator unit and the family wanted to meet and discuss the identified resident's care with him.

Allegation #2 was not substantiated due to insufficient evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The complainant stated he was not provided the resident's full medical record for the 72 hours prior to the resident's transfer and hospitalization, including respiratory therapist notes recorded in a "log" inside resident's room at the facility.

**FINDINGS #3:**

The Medical Record Supervisor was interviewed on February 4, 2015 at 3:00 p.m. He provided the medical record request the family submitted. The Medical Record Supervisor did not talk with the person who requested the records, but just copied the requested information checked on the family record request form. The family did not receive the complete record.

The respiratory therapy "log" information was not in the medical record for the four days prior to the resident being admitted to the hospital. The medical record request form did not have a place to check to get the information; however, the therapist's documents were located in the respiratory filing basket during survey.

Allegation #3 was substantiated and deficiency written at F153. The regulation allows for copies

Monica K. Brutsman, Administrator  
March 23, 2015  
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to be made upon oral or written request. The written request form used by the facility failed to include a place to request the complete record; it listed only different sections of the record to be checked for copies. The facility also failed to have a process for making verbally requested copies.

CONCLUSIONS:

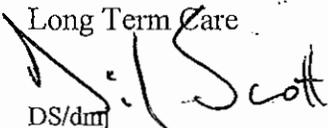
Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, R.N., Supervisor  
Long Term Care

  
DS/dmj