



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 24, 2015

FILE COPY

Sherrie Nunez, Administrator
Trinity Mission Health & Rehab Of Midland
46 North Midland Boulevard,
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **November 5, 2015**, a survey was conducted at Trinity Mission Health & Rehab Of Midland 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Sherrie Nunez, Administrator
November 24, 2015
Page 2 of 3

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 7, 2015**. Failure to submit an acceptable PoC by **December 7, 2015**, may result in the imposition of civil monetary penalties by **December 27, 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; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

A 'per instance' civil money penalty of **Federal Civil Money Penalty of \$750.00 per instance for the instance on November 5, 2015 described at deficiency F0323 (S/S: G).** and F0309 (S/S: G).

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 5, 2016**, 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.

Sherrie Nunez, Administrator
November 24, 2015
Page 3 of 3

If you believe these deficiencies have been corrected, you may contact 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.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)

[2001-10 IDR Request Form](#)

This request must be received by **December 7, 2015**. If your request for informal dispute resolution is received after **December 7, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



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

NS/pmt
Enclosures



**Trinity Mission Health & Rehab
of Midland**

RECEIVED

MAR - 3 2016

FACILITY STANDARDS

3/3/2016

David Scott
Idaho State Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720

Re: Addendum: Plan of Correction for Trinity Mission Health & Rehab of Midland
Credible Allegation of Compliance

Dear, David Scott:

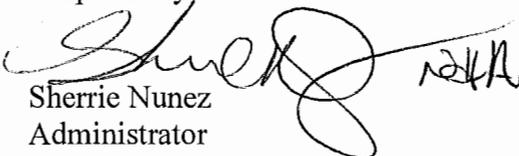
Enclosed you will find the revised Statement of Deficiencies completed, with the facility's Plan of Correction for the deficiencies identified in the survey dated for November 5, 2015.

Please consider this letter and the Plan of Correction to be the facility's credible allegation of compliance. The facility asserts substantial compliance with the applicable certification requirements on December 4, 2015

This letter is also the facility's request for a re-survey, if one is necessary, to verify that the facility has achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.

Thank you for your assistance in this matter.

Respectfully,


Sherrie Nunez
Administrator

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

PRINTED: 02/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2015
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

The following deficiencies were cited during a complaint survey of your facility.

The surveyors conducting the survey were:

Rebecca Thomas, RN, Team Coordinator
Linda Kelly, RN
Presie Billington, RN

The survey team entered the facility on November 2, 2015, and exited on November 5, 2015.

This report reflects changes resulting from the Informal Dispute Resolution (IDR) process conducted on February 18, 2016.

Survey Definitions:
ADL = Activities of Daily Living
ADON = Assisted Director of Nursing
BG = Blood Glucose
CNA = Certified Nurse Aide
DON = Director of Nursing
LN = Licensed Nurse
MAR = Medication Administration Record
mg/dl = Milligram per decaliter
NN = Nurses Notes
PRN = As Needed

F 000

Preparation and submission of this plan of correction by, *Trinity Mission Health & Rehab of Midland 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.

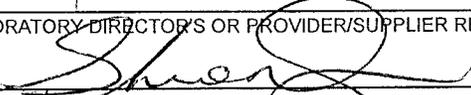
F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F-309

1. Resident # 1 discharged from the facility on 10/17/15.

2. On 11/30/15 an audit was completed by IDON and nurse managers of incidents and accidents for the previous thirty days, to ensure that assessment for injury, pain and necessary care, interventions and care plan was provided and followed; concerns were addressed at that time. 12/4/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 12/03/2015
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews it was determined the facility failed to follow physician orders for management of BG levels. This was true for 1 of 4 sampled residents (#6) reviewed for diabetes management: The facility failed to notify Resident #6's physician or implement interventions when blood glucose (BG) levels were less than 70 mg/dl, recheck the BG after interventions were implemented, and notify the physician when BG levels fell below 70 mg/dl or exceeded 400 mg/dl and interventions were refused. This deficient practice placed the resident at risk for complications related to unmanaged hyper- and hypoglycemia. Findings included: Resident #6 ws admitted to the facility in 2004 and readmitted in January of 2015 with multiple diagnosis including Type I diabetes mellitus, Rett's syndrome (a neurodevelopmental disorder) a history of pancreatitis and diabetic ketoacidosis.</p> <p>The resident's care plan documented the problem, "Labile blood sugars r/t [related to] IDDM [insulin dependent diabetes mellitus]" in February 2013. Goals included an A1C (lab test) below 7.0 and BGs in a range between 70-400 through 10/31/15. Interventions included consistent carbohydrate diet (CCD), dietary supplement and diabetic medications per orders, monitor for signs and symptoms (s/sx) of hypoglycemia and hyperglycemia and BGs as needed for s/sx of hypo/hyperglycemia.</p> <p>The resident's October 2015 recapitulation</p>	F 309	<p>On 11/30/15 an audit was completed by IDON and nurse managers of BG level for the last 30 days to ensure that Blood Glucose (BG) parameters ordered by MD were implemented including MD notification of BG lower than 70 or above 400.</p> <p>3. Root cause: Root cause analysis was completed by the IDT team on 11/18/15. It was determined that the LN did not identify potential injury during her initial assessment. On the LN progress note, initial assessment stated that the resident did not exhibit pain. There was no indication of any bruising. Resident's behavior appeared to the LN to be at baseline.</p> <p>Licensed staff provided interventions per physician order for BG less than 70 or greater than 400. The resident had orders for Glucerna to manage low BG during the night and since the BG was high the LN held the Glucerna related to the BG at 400 and assessed the resident at that time to not symptoms of hyperglycemia.</p>	

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F 309	<p>Continued From page 2</p> <p>(recap) of Physician Orders included Metformin 500 milligrams (mg) twice a day, Novolog 1 unit per 15 grams of carbohydrates (carbs) by subcutaneous (SQ) injection after meals (PC), both were dated 1/2/15, and Lantus (long-acting) 33 units every day before breakfast, dated 1/16/15. The CCD, 8 ounces of Glucerna at night, BG checks before meals, at bedtime and at 3:00 am, and A1C lab test orders were all dated 1/2/15. The order, "Record meal intake in MAR. If consumed < [less than] 50% of meal give 1 can Glucerna via bottle and document mls [milliliters] consumed" was dated 9/24/15.</p> <p>The October 2015 recap also included the following orders for hypo/hyperglycemia, "Glucagel Guideline: for BG < 70 and resident is alert, give 15 mg Glucagel P.O. [by mouth]. Re-check BG in 15 minures [sic]. Notify MD [physician]. If BG remains < 70 after Glucagel, provide snack/meal and re-check in 1 hour. Glucagon Guideline: for BG < 70 & [and] not alert, Glucagon 1 mg IM [intramuscular injection], re-check BG in 15 min. If BG remains < 70 & not alert, may repeat X [times] 1 to = 2 doses, Notify MD or call 911. If awake/alert, refer to Glucagel Guideline. If BG > [greater than] 400 administer insulin per orders notify MD." All of these orders were dated 4/28/15.</p> <p>A Facsimile Transmittal Sheet (fax) to the physician on 7/27/15 at 4:35 pm documented the resident's BGs were 422 before breakfast, 435 before lunch and 406 before dinner. The facility asked if the carb count could be discontinued and a higher sliding scale started. On 7/28/15, the physician replied, "...last A1C (June was 6.7). This is the best its been for quite awhile. Would base med changes on [resident's] next A1C."</p>	F 309	<p>Systemic change:</p> <p>When change of condition occurs the nurse shall assess, document and report the following baseline information as needed: Vital signs, neuro status, pain level or change in pain level, level of consciousness or participation, recent labs and active diagnosis. The physician shall be notified on acute change in condition based on assessment and information gathered including BGs outside of parameters.</p> <p>During morning clinical meeting, the IDT will review resident's change in condition to ensure that the resident received treatment, care plan followed and physician and responsible party were notified timely.</p> <p>Change of condition will include incidents and accidents and episodes of hypoglycemia or hyperglycemia and will be reported to the IDT via the 24 hour report.</p> <p>Beginning on 11/18/15 facility staff was re-educated by the IDON regarding assessment of resident change in condition, treatment and following,</p>	

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F 309	<p>Continued From page 3</p> <p>The MARs and Blood Glucose Tracking Sheets for July 1 through October 17 2015 documented the resident's BG was less than 70 twice before dinner in July, once before breakfast and three times at 3:00 am in August, once at 3:00 am in September, and once before dinner and three times at 3:00 am in October. These Blood Glucose Tracking Sheets documented a slash mark or arrow followed by a number, such as "48 [arrow] 101," for 3 of 4 low BGs in August, once in September, and for 3 of 4 low BGs in October. In addition, all of the spaces to document the administration of Glucagel or Glucagon were blank in the July through October MARs.</p> <p>Nurse's Notes (NN), dated 1/2/15 through 10/19/15, did not document the resident's condition, interventions, recheck BGs or physician notification when the resident's BG was less than 70 in July, August, September and October.</p> <p>The MARs and Blood Glucose Tracking Sheets documented the resident's BG was over 400 once before breakfast and twice before lunch and dinner in July, once before lunch and dinner in August, once before lunch in September, and on 10/17/15 at 3 am it was noted as 400. The spaces to document physician notification when the BG was over 400 were all blank in the July through October MARs.</p> <p>The NN contained a 7/27/15 entry which did not mention the three consecutively high BGs before each meal that day, and a 7/28/15 entry which noted the physician's reply as noted above.</p> <p>The resident was seen by the attending physician</p>	F 309	<p>care plan for transfers, LN will collaborate care with direct care staff and following physicians order related to BG less than 70 or higher 400.</p> <p>4. Beginning the week of 12/4/15 the IDON or designee will conduct audits of the 24 hour report, incidents and accidents and of BG levels, weekly for 4 weeks, then monthly for 2 months and quarterly thereafter to ensure the timely evaluation, treatment, MD and family notification of residents change in condition, adherence care plan, and to physician's orders regarding low and high blood sugars. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations for and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.</p> <p>Date of compliance 12/4/15</p>	

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F 309	<p>Continued From page 4</p> <p>on 10/16/15. The Assessment/Plan section of the office visit note documented the resident's most recent A1C was 0.7 on 9/7/15 and there were no significant episodes of hypoglycemia. The visit note also documented, "Continue current management...History of pancreatitis."</p> <p>The resident's record documented a fall from bed on 10/17/15 at 1:45 AM. At 3:00 AM, her BG was 400, re-checked with a second glucometer at 399. The NN documented, "No action taken @ this time. Scheduled 03:00...glucerna [sic] one 8 oz can held [secondary to] blood glucose 400. HS [bedtime] blood glucose documented as 228, report received...poor PO [oral] intake for the day of 10-16-15...Pt [patient] [without] s/sx hyperglycemia at this time..."</p> <p>On 10/17/15 at 7:10 am, NN documented the resident "flinched" and had s/sx of pain when examined at 6:50 am and a large purplish black bruise was noted at the resident's right hip and knee, the resident's BG before breakfast was "Hi [up arrow] 600," the BG was still over 600 after Lantus insulin was administered before breakfast, and a repeat BG was over 600 with "increase lethargy & s/sx [up arrow] hyperglycemia" noted. The physician was notified, 911 was called, the family was called and by 7:50 am, the resident was transported emergently to the hospital.</p> <p>On 11/4/15 at 4:25 pm, LN #1 said she worked the day shift on 10/17/15 and after report and narcotic count with the night nurse, she examined the resident who was in a wheelchair. The LN said normally the resident would push staff away and make a face but the only response to the exam that morning was the resident's facial expression. The LN said the resident's AC</p>	F 309	<p>F-323</p> <ol style="list-style-type: none"> 1 Resident # 1 discharged from the facility on 10/17/15. 2 On 11/30/15 an audit of other residents was completed by IDON and nurse managers to identify: <ul style="list-style-type: none"> A. assistance required while performing incontinence care B. residents on 15 minute check per plan of care C. residents requiring use of mechanical lift for transfer per plan of care; Concerns identified were addressed at that time. 	
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F 309 Continued From page 5

breakfast BG was over 600, she gave Lantus insulin as scheduled and rechecked the BG which was still over 600. The LN said the resident's breathing pattern changed and level of consciousness decreased. The LN said the resident's condition was "not good" and she had staff transfer the resident back to bed while the physician, then 911, was called and the family was notified.

On 11/5/15 at 11:15 am, the physician said the resident would eat what the resident wanted and the resident's BGs were always "up and down." When asked if he was notified each time the resident's BG was over 400, the physician said it was "standard protocol" to be notified but if not, "That really doesn't bother me." The physician said he was more concerned about severely low BGs than high BGs unless it was over 400 and the resident was symptomatic.

On 11/5/15 at 12:00 p.m., the ADON and LN #2 were shown the MARs, Blood Glucose Tracking Sheets and NN and asked to provide documentation regarding the time of interventions, if any, the time of recheck BGs, if any, and physician notification when the resident's BGs were less than 70. They were also asked for documentation of physician notification when the resident's BG was over 400. The ADON said the resident often refused Glucagel when the BG was low. The ADON was asked to provide that documentation. The ADON said they would get back with the surveyor.

LN #18 was on duty during the 10/17/15 night shift, which began at 6:00 pm on 10/16 and ended at 6:00 am on 10/17/15. Attempts to interview LN #18 by telephone or in person were

F 309

On 11/30/15 an audit was completed by IDON and nurse managers of incidents and accidents for the previous thirty days, to ensure that assessment, for injury, pain and necessary care and treatment was provided; concerns were addressed at that time.

On 11/30/15 an audit was completed by IDON and nurse managers of BG level for the last 30 days to ensure that BG parameters ordered by MD were implemented including MD notification of BG less than 70 or greater than 400; concerns were addressed at that time.

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F 309	Continued From page 6 not successful. LN #18 did not return any telephone calls on 11/5/15 even after the Administrator was informed and said the LN would stay by her telephone. LN #18 was not present for her scheduled shift on 11/5/15. The facility did not provide any other documentation regarding interventions, recheck BGs, resident refusals of Glucagel, physician notification about refusals of Glucagel or when the BGs were low or high.	F 309	Root cause: 3. Root cause analysis was completed by IDT team on 11/18/15. It was determined that:	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based interview and record review, it was determined the facility failed to adequately supervise and provide services to residents to prevent falls and injury. This was true for 1 of 3 residents (#6) sampled for falls and resulted in harm when Resident #6 fell out of bed and sustained bilateral femur fractures while staff were providing incontinence cares and required hospitalization. Findings included: Resident #6 was admitted to the facility in 2004,	F 323	a- Resident was provided assistance for incontinent care per plan of care. Resident rolled out of bed after the C.N.A. had completed incontinent care. The bed was in a low position (6 inches from fall matt to bed) when the resident rolled out of bed. b- 15 minute checks check sheet were completed and documented. c- Resident was transferred with blanket with 2 assist from fall pad to bed which approximately 6 inches in height per LNs judgement.	12/4/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ .B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2015
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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F 323	<p>Continued From page 7</p> <p>and readmitted January 2015, with Type I diabetes mellitus, seizure disorder, Rett's syndrome (a neurodevelopmental disorder), history of pancreatitis, and diabetic keotacidosis.</p> <p>The most recent quarterly MDS assessment, dated 10/4/15, documented the resident's cognition was severely impaired; required extensive assistance of 1 staff for bed mobility; total assistance of 2 staff for transfers; and was functionally limited in range of motion (ROM) in both lower extremities.</p> <p>The resident's ADL Care Plan, initiated 2/25/13, documented the resident required assistance with all ADLs, had developmental delay with the mentality of a one-year old, and care planned for the following approaches:</p> <ul style="list-style-type: none"> * Extensive assistance of 1 staff for bed mobility * Total assistance of 2 staff for toileting; * Incontinent of bowel and bladder, will not use the toilet, staff to check and change 2-3 times per shift and as needed (PRN), pericare and barrier cream after each incontinent episode; and, * May climb out of bed and walk on her knees. <p>The resident's Fall Care Plan, initiated 2/25/13, related to developmental deficits, no safety awareness, diabetes mellitus, seizure disorder and osteoporosis, and documented the following approaches:</p> <ul style="list-style-type: none"> * Two-staff assist with hoyer lift transfers; * Staff to monitor changes in condition that warranted increased supervision/assistance, and MD notification of these changes; * 15-minute checks for safety; * Bed in low position when in bed and due to ability to crawl on knees. 	F 323	<ul style="list-style-type: none"> d- It was determined that the LN did not identify potential injury during initial assessment. On the LN progress note, initial assessment stated that the resident did not exhibit pain. There was no indication of any bruising. Resident's behavior appeared to the LN to be at baseline. e- Licensed staff provided interventions per orders for BG less than 70 or greater than 400. f- LN staff had previously communicated to the physician a pattern of BG that were elevated greater than 400 and the physician did not give additional orders related to he was pleased with her A1C and would continue to monitor her A1C for managing the residents elevated BG. g- LN continued to monitor the resident for changes. When resident was noted to have a change the LN reassessed and responded by notifying emergency services per physician's orders and notified the family of the changes. 	

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F 323	<p>Continued From page 8</p> <p>A Pain Evaluation Form, dated 10/4/15, documented the resident was unable to verbalize pain but could indicate its presence with nonverbal/noncognitive expressions, including clenched jaw/teeth; moaning; gasping and crying/whimpering.</p> <p>An undated Fall Scene Investigation Report (FSIR) documented Resident #6 fell from bed while staff were in the room providing incontinent cares on 10/17/15 at 1:45 AM. An illustration on the FSIR depicted the resident laying on her right side on a fall mat approximately 12 inches from the bed and the bed was raised to a height of six inches from the floor at the time of the fall. The FSIR documented the resident was both rolling/sliding out of bed and sitting up in bed at the time of the fall. The FSIR did not document when the resident was last toileted prior to the incontinence care being performed at the time of the fall.</p> <p>A Resident Incident Report (RIR), dated 10/22/15, documented an RN assessed the resident for injury, assisted Resident #6 back to bed, and the resident was then monitored for injury.</p> <p>A 10/27/15 witness statement by CNA #19 documented she provided incontinence care alone for Resident #6 at the time of the fall. CNA #19 did not state when the resident last received a 15-minute check, when incontinent care was last provided, or why a second staff did not assist with toileting the resident as care planned.</p> <p>The 10/27/15 witness statement and an 11/5/15 interview with CNA #19 revealed she provided incontinence care at 1:45 - 1: 50 AM, changed and lowered the resident's bed, and turned and</p>	F 323	<p>Systemic change:</p> <p>When change of condition occurs the nurse shall assess, collect, document and report the following baseline information as needed: Vital signs, neuro status, pain level or change in pain level, level of consciousness, recent labs, BGs per physician orders and active diagnosis and care plan. The physician shall be notified on acute change in condition based on information gathered. The LN and direct care staff will communicate regarding residents change of condition.</p> <p>During the morning clinical meeting, the IDT will review resident's change in condition reported by LN via 24 hour report to ensure that the resident received necessary care and treatment, care plan followed and physician and responsible party was notified timely. Change of condition will include Incident and accident and episodes of hypoglycemia and hyperglycemia.</p>	

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F 323	Continued From page 9 stepped away from the bed to retrieve a blanket from the window cabinet ledge when the resident fell. The statement documented the resident "flipped" or "rolled" out of the left side of the bed and onto her right side. CNA #19 stated the resident appeared "startled or scared" and began to cry, but otherwise did not move or crawl around. The CNA activated the call light for assistance. LN #18 responded to the call light, moved the resident's arms and legs, and then instructed and assisted CNA #19 to roll the resident back and forth onto a bed sheet, which was then used to slide the resident back into bed. CNA #19 stated she was unsure why LN #18 directed the use of a bed sheet to transfer the resident, other than because the bed was in a low position. CNA #19 stated LN #18 did not want vital signs taken because the resident was care planned to crawl out of bed and around on the floor, so this event was not considered a fall. CNA #19 was unable to explain how LN #18 determined the resident purposefully crawled out of bed given her own description of the event and Resident #6's demeanor at that time. A Nurse's Note (NN) by LN #18 and dated 10/17/15 at 7:00 AM documented the ADON was notified the resident "rolled out of bed to the floor mat," the bed was in the lowest position during cares, and the resident did not have obvious injury. The NN documented the event occurred at 1:45 AM and that the nurse assessed Resident #6 approximately five minutes later. The resident was noted to have 20 bpm (breaths per minute) that were even and unlabored; was tearful; and displayed no bruising, abrasions, or evidence of pain when passive range-of-motion was performed to her wrists and ankles. The NN documented the resident was assisted back into	F 323	Beginning on 11/18/15 facility staff was re-educated by the IDON regarding assessment of resident change in condition, treatment and following care plan for cares and transfers, LN and direct care staff will collaborate care with change of condition and following physicians order related to BG less than 70 or higher 400. 4. Beginning the week of 12/4/15 the Interim Director of Nursing or designee will conduct audits of incident and accidents, change of conditions, and BG orders weekly for 4 weeks then monthly for 2 months and quarterly thereafter to ensure the timely notification of physician and family with a change of condition, timely assessment including vital signs and adherence to plan of care related to mechanical lift transfers, and		

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F 323	<p>Continued From page 10</p> <p>bed with bed linen by "sliding" with two person assist, which she tolerated without pain or discomfort. The NN documented cares were administered to the resident for the remainder of the night shift with no unusual behaviors noted.</p> <p>It could not be determined how Resident #6 was assessed to be free of pain when tearfulness was documented as one of the resident's nonverbal expression of pain; vital sign documentation after the event did not include blood pressure, heart rate, temperature or oxygen saturations; and it was unclear why the resident was assisted back into bed with a sliding bed linen rather than the Care Plan-required mechanical lift.</p> <p>A summary witness statement and facility interview of by LN #18 documented she entered the room to find the resident on her right side on a padded mat next to the low bed. The statement documented the resident had tears in her eyes. After assessing PROM (passive range of motion) to all joints, LN #18 rolled the resident onto her back and assessed ROM to the resident's hips and pelvis. LN #18's statement documented Resident #6 did not have any painful response to assessment and she did not think the resident was seriously hurt. The statement documented LN #18 discussed the fall with CNA #19, who reported the resident "just appeared to accidentally roll off/out of bed." The statement did not document why the resident's vital signs were not taken at this time or why Resident #6 was transferred back to bed by "sliding" her with a bed sheet rather than the mechanical lift as required by the resident's Care Plan.</p> <p>The resident's record did not document whether 15-minute checks were completed as care</p>	F 323	<p>treatment per assessment was provided. A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. At that time the QAPI will make recommendations for and determine continued monitoring. The Director of Nursing will be responsible for monitoring and follow-up.</p> <p>Date of compliance 12/4/15.</p>	

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planned, and none of the witness statements or interviews confirmed the checks were completed.

CNA #19's typed statement documented she asked LN #18 to check on the resident, who she could hear crying and whimpering intermittently between 2:30 and 3:00 AM.

LN #18's statement documented the resident's blood glucose (BG) level was 400- and 399 mg/dl at 3:00 AM. At 4:30 AM, LN #18's statement documented CNA #19 told her Resident #6 was tearful during cares, which LN #18 perceived as fear. Between 5:00 and 5:30. AM, LN #18 "checked on" the resident who was "sleeping" with even respirations. At 6:00 AM, LN #18 provided report to an oncoming day shift LN. LN #18's statement documented CNA #14 asked her to assess the resident, now in the shower room, but this request "did not indicate any urgency."

Several attempts were made to contact LN #18 for interview during survey, but the LN could not be reached, did not return phone calls, and did not report for work at the facility as scheduled while survey was in process.

CNA #14's written witness statement documented that at 6:10 AM she and CNA #20 rolled the resident to remove her pajama pants and placed the mechanical lift sling under the resident. CNA #14 stated Resident #6 whimpered during movement and that there was a bruise emerging on the resident's right knee. CNA #14 stated she perceived the resident's whimpering as she was transferred by mechanical lift to a shower gurney as an expression of fear rather than of pain. There was no documentation the nurse was alerted or that the resident was assessed prior to-

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F 323	<p>Continued From page 12</p> <p>or during the transfer. At 6:15 AM, CNA #14 took the resident into the shower room and rolled the resident side-to-side to remove her adult brief and Hoyer lift sling. Resident #6, who was documented as normally sitting up with her legs crossed and inclined to play with the water during showers, laid still on the gurney on this day, according to CNA #14's written witness statement, which noted the resident appeared "traumatized" following the fall.</p> <p>CNA #14's written statement documented she opened the shower room door at 6:25 AM and called to nurses in shift report down the hall that Resident #6 was in pain. The statement documented LN #1 looked up from report but did not respond. CNA #14 then completed the resident's shower, partially dressed and covered her, and took her back to her room. CNA #20 joined CNA #14 to dress the resident and LN #1 instructed the two CNAs to transfer the resident to her W/C, which was accomplished with a Hoyer mechanical lift. At 7:15 AM, CNA #14 was asked to assist the resident back into bed.</p> <p>CNA #20's written statement for the 10/17/15 event documented CNA #19 reported to her that Resident #6 rolled out of bed and onto the padded mat that morning and now appeared "traumatized." CNA #20 stated there was a change in the resident's normal level of participation and demeanor during the transfer from bed to shower gurney.</p> <p>A NN by LN #1, dated 10/17/15 at 7:10 AM, documented Resident #6 was receiving a shower at 6:30 AM when a CNA reported an increase in pain to the resident's right hip and leg as she was transferred and repositioned to a shower gurney.</p>	F 323		

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The NN documented the resident was examined at 6:50 AM, after the resident was showered and placed in a W/C (wheelchair). LN #1 documented she examined the resident's right hip and knee, where she noted a large purplish black bruise. LN #1 stated the resident flinched with increased signs of pain during the assessment, recorded a BG reading exceeding 600 mg/dl, and was increasingly lethargic.

A summary witness statement and interview for LN #1 documented CNA #14 asked her to see the resident in the shower room at 6:25 AM. LN #1 did not perceive this request to be urgent, and told CNA #14 she would check after morning report. At 7:00 AM, EMS was called after the resident's third consecutive BG check of "Hi[gh] 600 [mg/dl]," and an observed change in the resident's breathing. LN #1 called the physician, had staff assist the resident to bed, and readied information for the hospital and paramedics, who arrived at approximately 7:15 AM and transported Resident #6 to a local hospital.

On 11/4/15, LN #1 stated she worked the day shift on 10/17/15 and after report and narcotic count with the night nurse, she examined the resident who was then in a wheelchair. The LN said normally the resident would push her away and make a face, but the only response to the exam that morning was the resident's facial expression. The LN said the resident's BG was over 600 mg so she gave Lantus (long acting, not quick acting) insulin as scheduled and rechecked the BG, which was still over 600 mg/dl. The LN said when the resident's breathing pattern changed and her level of consciousness decreased, she determined Resident #6's condition was "not good" and she had staff

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F 323	<p>Continued From page 14</p> <p>transfer the resident back to bed while the physician then 911 was called and the family was notified of the need for emergency services.</p> <p>On 11/5/15, CNA #14 stated she and CNA #20 went into Resident #6's room on 10/14/15 at 6:05, where they found the resident in bed on her back with her right leg "bent" outwards. She noticed a bruise-like ring closer to the inside of the leg by the knee. The resident groaned, the hoyer sling was placed under the resident, and she was transferred to the shower gurney. The CNA stated the resident was "normally" alert, had more color and liked to sit up in the shower and play in the water, but that morning she only laid still on the gurney. CNA #14 stated the resident yelled and grabbed her shirt when she washed the resident's peri-area, and the resident's leg was turned inward. CNA #14 stated at this point, she realized the resident was in pain so she opened the shower door and yelled for a nurse. When no nurses responded, CNA #14 said she finished the shower, dressed the resident, and took her back to her room. On the way back to the resident's room, CNA #14 stated, she asked LN #1 whether the resident should be laid down or positioned in her chair; LN #1 directed CNA #14 to transfer the resident to the chair, where she appeared uncomfortable and made groaning noises. After the resident was transferred via hoyer mechanical lift to her chair, CNA #14 stated, LN #1 did not come in until approximately one-half hour later. CNA #14 stated she was concerned for the resident's safety, and felt the nurse should have come more quickly to assess the resident.</p> <p>Resident #6 was harmed when she was hospitalized following a fall from bed when: *The CNA provided incontinence care alone,</p>	F 323		
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F 323	Continued From page 15 rather than with two staff as required in the care plan; *The CNA turned away from the resident before cares were completed, and the resident fell from bed; *The resident was lifted back into bed by a bedsheet, rather than by mechanical lift required for her transfers; *15 minute checks, which were part of the resident's care plan, were not performed after the fall; *Licensed nursing staff did not assess developing symptoms of injury and shock, including an evaluation of the risk to the resident prior to three additional transfers and a bathing activity; and *Licensed nurses did not respond with the urgency to the CNA's requests to assess the resident's developing symptoms.	F 323		



IDAHO DEPARTMENT OF
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RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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February 22, 2016

Sherrie Nunez, Administrator
Trinity Mission Health & Rehab Of Midland
46 North Midland Boulevard,
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

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

Complaint #ID00006808

This complaint was investigated in a complaint survey conducted on November 2, 2015 to November 5, 2015.

The following observations were made:

Direct care staff and management staff interactions with the identified resident and multiple other residents;
Direct care staff during the provision of care to the identified resident and four other residents;
and,
A dressing change for the identified resident.

The following documents were reviewed:

The medical records for nine residents, including the identified resident; and,
The facility's grievance files, incident and accident reports, and reports of allegations of abuse;
and,
The home health medical record of the identified resident.

The following interviews were completed:

Several direct care staff were interviewed regarding quality of care concerns;
The Assistant Director of Nursing (ADON), a Social Worker (SW) and Administrator were interviewed regarding various quality of care concerns; and,
The Branch Director and Regional Administrator of the home health agency.

Allegation #1: The complainant stated the facility showered the identified resident on December 17 or 18, 2014 and the wound dressings became wet. The complainant stated the nurse told her to come back the next day and she would show her how to perform the dressing changes. The next day the dressing change took one hour, and a foul odor was noticed by the complainant. The complainant didn't know why the dressing took one hour.

Findings #1: A licensed nurse (LN) was observed as she performed a wet to dry dressing change to venous stasis ulcers on the identified resident's bilateral lower extremities. The resident was tearful and stated she was scared but felt the facility did a pretty good job with her dressing changes.

A January 22, 2015 Investigation Summary documented the facility's investigation regarding the shower and wet dressing incident. A review of the identified resident's nurses notes on December 19, 2014, documented the resident had declined the dressing change earlier in the afternoon because the resident had company. Dressing changes were done at 8:30 PM. The resident's power of attorney (POA) arrived at 9:00 PM and said she would be taking the identified resident out of the facility AMA (against medical advice) now. The LN documented she explained this was not in the resident's best interest as the wounds were "greatly" improving. The POA was asked to come back the next day to observe the improvement. A December 20, 2014 nurses note documented the dressing change was done with the POA present. The identified resident desired to return home, was discharged home with the POA on December 22, 2014, and few therapy goals had been met. It was determined this allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Sherrie Nunez, Administrator
February 23, 2016
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Allegation #2: The resident was discharged from the facility on December 22, 2014 to home with home health, and the facility did not send home supplies for wound treatment. A home health agency was not given any instructions or supplies. Medicated ointment was not put on to the wounds from December 22, 2014 until December 26, 2014 because a new order had to be obtained.

Findings #2: Review of the identified resident's record, documented on December 20, 2014, the facility faxed to the home health agency a face sheet, discharge orders, history and physical, medication administration record, treatment administration record, physical therapy and occupational therapy treatment notes.

The identified resident's medical record from the home health agency was reviewed. A home health certification and plan of care with a start of care date of December 23, 2014, documented physician orders were received on December 22, 2014. It documented wound care orders, treatment, DME (durable medical equipment) and supplies were in the home. A December 23, 2014 home health skilled nurse visit note documented wound care was performed to the venous ulcers, cleansed with wound cleanser and gauze, applied Santyl Ointment with tongue depressor to all open wounds, covered with adaptic and exudry/foam, secured with gauze and Coban via clean technique. No documentation was found that the supplies or ointment were low or needed to be ordered on December 23, 2014. The home health agency's Regional Administrator and Branch Manager were interviewed and stated they visited with the resident and the resident's power of attorney (POA) the week prior to discharge from the facility, and did receive the faxed information from the facility on December 20, 2014 at 1:47 PM. The Branch Director stated it looked like the orders and supplies were in the resident's home. He stated there was no indication from their first visit there were not adequate supplies. He stated the home health agency did have challenges with coordination. It was determined the allegation could not be substantiated.

Conclusion #2: 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,



DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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March 8, 2016

Sherrie Nunez, Administrator
Trinity Mission Health & Rehab Of Midland
46 North Midland Boulevard,
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **November 5, 2015**, an unannounced on-site complaint survey was conducted at Trinity Mission Health & Rehab Of Midland. The complaint allegation, finding and conclusion are as follows:

Complaint #ID00006962

The clinical records for the identified resident and eight other residents were reviewed. The facility's grievance files, incident and accident reports, medication error reports, and investigations of allegations of abuse were also reviewed, as were abuse policies and procedures.

Five residents, four licensed nurses, three Certified Nursing Assistants, three therapy staff, the Acting Director of Nursing, a Social Worker, and the Administrator, were interviewed about various quality of life and quality of care issues, including pain management, residents' participation in therapy, and abuse.

The survey team observed interactions between direct care staff and five residents during the provision of care and therapy, as well as management staff interactions with several residents in general.

Allegation: An identified resident is being "chemically abused." The resident is overmedicated to the point of being too drowsy to participate in prescribed therapies necessary for progress to discharge. The resident has been receiving Oxycodone for pain and is experiencing side effects of sleepiness, tremors, and itching.

Benadryl was prescribed for itching, compounding the drowsiness. In a family meeting on March 15 or 16, 2015, the nursing supervisor yelled at the resident in an effort to keep the resident awake for the meeting.

Finding: Based on review of the identified resident's clinical record, grievance files, and staff interviews, it was determined the resident was admitted to the facility with multiple diagnoses, including chronic pain, arthritic knee pain, and a skin condition with itching related to antibiotic allergies. Orders for three scheduled pain medications, including a long-acting pain patch, Oxycodone, and topical lidocaine, and as needed, Oxycodone and Tylenol, were in place on admission for the pain. The resident was always able to make his/her needs known and to request the as needed pain medication. The results were positive when as needed Oxycodone was administered. Movement, especially during physical therapy, caused increased pain. The pain patch dose was increased and a muscle relaxant and nerve pain medication were added to manage the pain, again with positive results documented. The resident said the pain medication changes made it easier to participate in therapy. Benadryl twice a day and another anti-itch medication were also ordered on admission for the skin condition. The Benadryl was decreased on April 10, 2015. Two days later, the resident was noted to be sleepy. On April 13, 2015, physical therapy was discontinued due to the resident's refusals to participate due to pain. The resident continued to work with occupational therapy and speech therapy. During the following week, the resident complained of persistent and increased pain and as needed Oxycodone was administered with decreased pain, but continued sleepiness and lethargy was noted afterward. Though sleepy, the resident still worked with occupational and speech therapy during this time. The physician was consulted about the sleepiness/lethargy and initially he/she did not make any medication changes because it would compromise the resident's pain control. Two days later, when pain control was maintained, the physician decreased the frequency of the scheduled Oxycodone and changed the anti-itch medications to as needed. The resident was more alert after that.

The resident was not in the facility on March 15th or 16th, 2015. An April 16, 2015 care conference, in which the resident, two family members, and three facility staff were present, documented there had been medication changes to help manage the pain and that the resident had been "more sleepy." There was no documented evidence the resident was asleep or sleepy during the care conference. In addition, staff who participated in the care conference were interviewed and all of them denied that any staff had yelled at the resident to keep him/her awake.

The facility managed the resident's chronic pain and skin condition appropriately and according to the physician's orders. The allegation was not substantiated.

Sherrie Nunez, Administrator
March 8, 2016
Page 3 of 3

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As the allegation was unsubstantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink, appearing to read "Nina Sanderson". The signature is written in a cursive, flowing style.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



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February 24, 2016

Sherrie Nunez, Administrator
Trinity Mission Health & Rehab Of Midland
46 North Midland Boulevard,
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

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

Complaint #ID00007058

This complaint was investigated in a complaint survey conducted on November 2, 2015 to November 5, 2015.

The following observations were made:

Direct care staff and management staff interactions with the identified resident and multiple other residents; and,
Direct care staff during the provision of care to four residents.

The following documents were reviewed:

The medical records for nine residents, including the identified resident; and,
The facility's grievance files, incident and accident reports and reports of allegations of abuse.

The following interviews were completed:

Several direct care staff were interviewed regarding quality of care concerns; and, The Acting Director of Nursing (ADON) and Administrator were interviewed regarding various quality of care concerns.

Allegation #1: The complainant stated the resident stated on admission that the bed was "digging in to her" and "cutting off her circulation to different parts of her body." A staff member, in essence, stated, "Too bad so sad. You have a cell phone and call 9-1-1 if you want, but if you do you will be on your own and responsible for getting yourself home to Walla Walla.

Finding #1: The admitting nurse was interviewed and stated the resident was extremely emotional when she first arrived at the facility, was inconsolable and very unhappy about having to move from a longterm acute care hospital to the facility. The nurse stated the bed situation was taken care of within a 24 hour period. The resident had a brand new alternating air bed and the resident was happy with it after it was changed to a different setting. The nurse was asked about telling the resident, in essence, "Too bad so sad, you have a cell phone, can call 9-1-1 but would be responsible for getting herself to Walla Walla." The admitting nurse stated she would never talk that way to her patients. She stated, "No way did I say call 9-1-1, you are on your own and responsible for getting yourself home to Walla Walla." She stated she called her administrator who told her to give the resident options or choices she could pursue if she wanted to leave.

The ADON (Acting Director of Nursing) was interviewed and stated the resident was supplied with a brand new specialty bariatric bed which was powered by an alternating mattress. It had two power adjustments and was changed to a static setting versus the alternating setting the next day and the resident was happy. It was determined this allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The complainant stated the resident was awake and in pain the entire evening of June 15, 2015, although she received scheduled pain meds.

Findings #2: Record review of the resident's Medication Administration Record (MAR) and nursing notes documented the resident was admitted with pain medication, which was given as scheduled and on an as needed basis. Nurses notes for the first night documented the resident calmed down and slept well. It was determined this allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The complainant stated the resident was not supplied with CPAP (Continuous Positive Airway Pressure) per her sleeping routine.

Findings #3: A Licensed Nurse (LN) and the Acting Director of Nurses (ADON) were interviewed and stated the resident was admitted with her own CPAP (Continuous Positive Airway Pressure) machine. The LN said the resident stated the CPAP wasn't flowing as well as it had before and he found the tubing had been crimped right at the connection to the machine. He changed the tubing, turned on the CPAP machine and the resident stated it worked much better. He stated a new CPAP machine and tubing was delivered on June 16, 2015. It was determined this allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The complainant stated the identified resident's blood glucose (BG) was very low and staff took a long time to respond. Also, staff were not washing their hands prior to assessing BG levels and didn't recheck the BG level for thirty minutes.

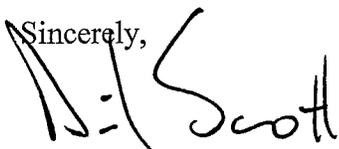
Findings #4: Three staff were observed as they checked blood glucose (BG) levels and were observed to wash their hands before assessing BG levels. The staff were observed to be proficient in BG level checks and hand washing.

The resident's medical record was reviewed and the Medication Administration Record (MAR) documented the resident refused Glucagel for a low BG the night she was admitted, and was given orange juice, graham crackers and peanut butter per her request. The physician was notified of the low BG level, and the BG was rechecked after the resident had eaten. Record review of the MAR documented the facility followed their diabetic management protocols each time the resident's BG level was low. It was determined the allegation could not be substantiated for this resident, but was substantiated for other residents during the complaint survey process.

Conclusion #4: Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have 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, RN, Supervisor
Long Term Care



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 8, 2016

Sherrie Nunez, Administrator
Trinity Mission Health & Rehab Of Midland
46 North Midland Boulevard,
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

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

Complaint #ID00007179

This complaint was investigated in an on-site complaint survey conducted on November 2, 2015 to November 5, 2015.

The clinical records of the identified resident and eight other residents were reviewed. The facility's grievance files, incident and accident reports, and investigations of allegations of abuse were also reviewed as were facility policies and procedures regarding falls, mechanical lifts, and diabetes management.

Interviews were conducted with several licensed nurses and Certified Nursing Assistants regarding quality of care issues, including fall prevention and care after a fall, mechanical lift usage, and diabetes management. The Acting Director of Nursing and the Administrator were also interviewed about various quality of care concerns, including the identified resident's fall, diabetes management, and notification when there was a change in the resident's condition.

Additionally, two physicians were interviewed about the identified resident's fall and diabetes management.

The survey team observed interactions between several direct care staff and residents during the provision of cares, including staff assisted transfers and mechanical lift transfers.

Allegation#1: The identified resident's responsible party was not notified of a fall.

Finding #1: Based on review of the identified resident's clinical record, incident report, and staff interviews, a licensed nurse assessed the resident to be without injury after a fall out of bed at 1:45 am on October 17, 2015. By 3:00 am, the resident's blood glucose level was 399 to 400, which was not unusual according to the resident's physician. A day shift nurse documented that at 6:50 am, the resident was in pain after mechanical lift transfers and a shower and the resident's blood glucose before breakfast was over six hundred. The nurse administered the resident's scheduled long acting insulin and rechecked the blood glucose, which was still over six hundred. The resident then became lethargic and was transferred back to bed. The record documented that shortly after that, the resident's breathing pattern changed and level of consciousness decreased; the physician was notified, 911 was called, the responsible party was notified, and by 7:50 am, the resident was transported emergently to the hospital via ambulance.

The allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: There are questions about the circumstances of the identified resident's fall on October 17, 2015, including the height of the bed, staff supervision at the time of the fall, and whether the resident was properly assessed after the fall.

Finding #2: Based on review of the identified resident's clinical record, incident/accident report, and staff interviews, a night shift Certified Nursing Assistant provided incontinence care alone rather than with two staff as care planned then turned and stepped away and the resident fell from bed on October 17, 2015. A Licensed Nurse was summoned and together they lifted the resident back into bed using bed linens rather than a mechanical lift as care planned. In addition, care planned fifteen minute checks were not completed after the fall and the nurse did not assess developing symptoms of injury and shock, including evaluating the risk to the resident prior to three mechanical lift transfers and a bathing activity.

The allegation was substantiated and the deficient practice was cited at the harm level at F 323.

Conclusion #2: Substantiated. Federal deficiencies related to the allegation are cited.

Sherrie Nunez, Administrator
March 8, 2016
Page 3 of 3

Allegation #3: Using a mechanical lift to get the identified resident out of bed, then a shower, and getting ready for breakfast caused additional pain, and the resident's blood glucose was elevated from traumatic injury and pain.

Finding #3: Based on review of the identified resident's clinical record, incident report, and staff interviews, the resident experienced increased pain and his/her blood glucose levels were over six hundred three times after three mechanical lift transfers, a shower, and while seated in a wheelchair before breakfast.

The allegation was substantiated and the deficient practice was cited at F 309.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it was 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,

A handwritten signature in cursive script, appearing to read "Nina Sanderson".

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt