



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

February 1, 2016

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

Provider #: 135076

Dear Ms. Nunez:

On **January 8, 2016**, a survey was conducted at your facility. You have alleged that the deficiencies cited on that survey will be corrected. We are accepting your Plan of Correction.

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,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



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January 19, 2016

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

Provider #: 135076

Dear Ms. Nunez:

On **January 8, 2016**, we conducted an on-site revisit to a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 4, 2015**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **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
January 19, 2016
Page 2 of 4

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 28, 2016**.

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 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*.

As noted in the Bureau of Facility Standards' letter of **November 24, 2015**, following the survey of **November 5, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **May 5, 2016**, if substantial compliance is not achieved by that time. The findings of non-compliance on **January 8, 2016**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **January 6, 2016**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **February 5, 2016**

Sherrie Nunez, Administrator
January 19, 2016
Page 3 of 4

- A 'per instance' civil money penalty of **Federal Civil Money Penalty of \$3600.00 per instance for the instance on November 5, 2015 described at deficiency F0323 (S/S: G)**

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

If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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 **January 28, 2016**. If your request for informal dispute resolution is received after **January 28, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Sherrie Nunez, Administrator
January 19, 2016
Page 4 of 4

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,

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

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

NS/pmt
Enclosures



**Trinity Mission Health & Rehab
of Midland**

1/27/2016

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

RECEIVED

JAN 28 2016

FACILITY STANDARDS

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

Dear, David Scott:

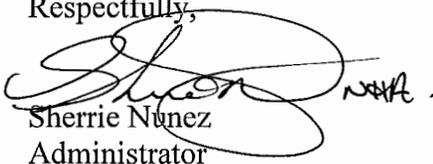
Enclosed you will find the Statement of Deficiencies completed, with the facility's Plan of Correction for the deficiencies identified in the follow up survey dated for January 8, 2016

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 January 27, 2016

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: 01/15/2016
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 R-C 01/08/2016
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651	
(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}	<p>INITIAL COMMENTS</p> <p>An on-site follow-up to a complaint survey was conducted from January 6, 2016 to January 8, 2016.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Angela Morgan, RN, BSN</p> <p>Definitions: ADL - Activities of Daily Living CNA - Certified Nursing Assistant IDT - Interdisciplinary Team LN - Licensed Nurse MDS - Minimum Data Set ROM - Range of Motion</p> <p>F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, review of medical records, abuse policy and procedure, and incident/accident reports, it was determined the facility failed to ensure a bruise of unknown origin was investigated per the facility's policy. This was true for 1 of 6 (#17) sampled residents. Failure to follow the policy for investigating the injury placed this resident, and all other residents who lived in the facility, at risk for abuse and/or neglect. Findings included:</p>	{F 000}	<p>Preparation and submission of this plan of correction by, <i>Trinity Mission Health & Rehab of Midland LLC</i>, 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.</p> <p>F 226</p> <ol style="list-style-type: none"> 1. Resident # 1 discharged from the facility on 1/11/2016 2. On 1/22/2016 an audit was completed by the Administrator and Social Service Director of the last 30 days of residents noted to have injury of unknown origin to include bruises to ensure a thorough investigation was completed for each incident per facility Abuse Investigation policy to include; 	

RECEIVED
JAN 28 2016
FACILITY STANDARDS

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

TITLE

(X6) DATE

[Signature] NHA

NHA

1/27/16

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 226	<p>Continued From page 1</p> <p>Resident #17 was admitted to the facility with diagnoses of Alzheimer's disease, anxiety disorder, major depressive disorder, and chronic pain.</p> <p>The Admission MDS, dated 11/28/15, documented, the resident was non-verbal, required total dependence of two or more staff for bed mobility and transfers, and required staff assistance for stabilization with surface-to-surface transfers.</p> <p>The current ADL, Mood, and/or Fall care plan documented interventions including two person total assist for transfers via Hoyer lift; monitor behaviors including swinging out at staff, combativeness, constant movement of arms and legs, and grabbing at things in the air and on the wall; and bilateral one quarter side rails to aid in functional bed mobility.</p> <p>The facility's undated Abuse Investigation policy and procedure documented injuries of unknown origin will be promptly and thoroughly investigated. The individual conducting the investigation will review the resident's medical record to determine events leading up to the incident. Interviews will be completed with the person(s) reporting the incident, witnesses to the incident, staff members (on all shifts) who had contact with the resident during the period of the incident; the resident's roommate, family members, visitors; and other residents with whom the individual(s) provide care or services to and/or interacts.</p> <p>A Resident Incident report dated 12/06/15 documented the day shift CNA reported Resident</p>	F 226	<ul style="list-style-type: none"> Review of the medical record. Interview the person(s) reporting the incident; Interview witnesses to the incident; Interview the resident (as medically appropriate Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors Interview other residents with whom the individual provides care or services and/or interacts as necessary; concerns were addressed at that time. 		

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F 226	<p>Continued From page 2</p> <p>#17 had a blue/purple bruise to her right eye and it measured 4 centimeters in diameter. The bruise had not been identified and/or reported by the CNAs or nurses on either the preceding evening or night shift.</p> <p>The Resident Incident Follow-up dated 12/07/15 documented, "after interviewing staff and assessing for possible causes of the injury it was found that bruising was most likely caused during cares as resident has been observed to sit up in Hoyer and come close to making contact with the bar..." The completed Incident Report did not include witness statements and/or interviews with the reporting CNA; witnesses to the incident; staff members on the evening shift and night shift who had contact with the resident on 12/05/15 and 12/06/15; the resident's roommate; and other residents who received care from the evening and night shift CNAs and nurses.</p> <p>The resident's Nurses Notes and care plan from 11/20/15 to 12/06/15 did not document concerns related to the resident's face making contact with the bar on the Hoyer lift.</p> <p>The resident's Nurses Notes contained an IDT review dated 12/06/15, which documented staff were interviewed and stated at times the resident would sit-up[forward] during Hoyer transfers and her right eye would come in close contact with the cross bar on Hoyer lift, "therefore it was determined the bruise was consistent with the resident's eye making contact with Hoyer lift."</p> <p>On 1/08/16 at 1:30 pm the Administrator stated the incident was not reported to the State Agency because the facility had determined in a "very short time" abuse had not occurred. The</p>	F 226	<p>3. ROOT cause:</p> <p>Root cause analysis was completed by interdisciplinary (IDT) team on 1/22/2016. It was determined that the facility did not have supporting documentation of the investigation conducted on a bruise to include;</p> <p>Documented interviews, of the staff reporting the incident.</p> <p>Documented interviews from staff who would have had contact with the resident during the period of the incident.</p> <p>Documented interview of roommate, family members and visitors,</p> <p>Systemic change:</p> <p>Systemic change will include that in the event of an injury of unknown origin; the staff will notify the abuse coordinator upon initial findings. The Abuse Coordinator will initiate and coordinate the investigation per facility abuse investigation to include;</p>	

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F 226	Continued From page 3 Administrator stated LN #1 observed the location and shape of the bruise and felt it was consistent with the location of the bar on the Hoyer lift. The Administrator stated on 12/05/15, the evening shift transferred the resident via Hoyer without incident and the Hoyer was not used on the night shift. The Administrator was unable to provide documentation that interviews were completed with the person(s) reporting the incident, witnesses to the incident, staff members (on all shifts) who had contact with the resident during the period of the incident; the resident's roommate, family members, visitors; and other residents with whom the individual(s) provide care or services for. The Administrator stated she did not feel the bruise of unknown origin was related to abuse and therefore, it was not investigated per the facility's abuse policy.	F 226	<ul style="list-style-type: none"> • Review of the medical record. • Interview the person(s) reporting the incident; • Interview witnesses to the incident; • Interview the resident (as medically appropriate) • Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; • Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; • Interview the resident's roommate, family members, and visitors; • Interview other residents with whom the individual provides care or services and/or interacts as necessary. 		

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Date of compliance 1/27/2016