



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

March 9, 2016

Gerald Bosen, Administrator
Trinity Mission Health & Rehab of Holly
2105 12th Avenue Road
Nampa, ID 83686-6312

Provider #: 135094

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

Dear Mr. Bosen:

On **March 1, 2016**, a Facility Fire Safety and Construction survey was conducted at **Trinity Mission Health & Rehab Of Holly** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 22, 2016**. Failure to submit an acceptable PoC by **March 22, 2016**, may result in the imposition of civil monetary penalties by **April 11, 2016**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 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 **April 5, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 5, 2016**. A change in the seriousness of the deficiencies on **April 5, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 5, 2016**, includes the following:

Denial of payment for new admissions effective **June 1, 2016**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 1, 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, it will provide you with a separate formal notification of that determination.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 1, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

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

This request must be received by **March 22, 2016**. If your request for informal dispute resolution is received after **March 22, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'M.P. Grimes', followed by a horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLI	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) COMPLETION DATE
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K 000

INITIAL COMMENTS

The facility is a single story Type V (III) structure built in 1998 with an addition of 60 beds in March 2001. The facility is sprinklered throughout with smoke detection coverage in corridors, sleeping rooms, and open spaces. The facility is currently licensed for 120 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on March 1, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.

K 000

Preparation and submission of this plan of correction by, Trinity Mission Health and Rehab of Holly, does not constitute an admission or agreement by the provider of the facts alleged or the correctness of the conclusion 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.

The surveyor conducting the survey was:

Sam Burbank
Health Facility Surveyor
Fire Life Safety & Construction

K064

Specific Residents

1. On 03/01/2016 the Maintenance Director (MD) repositioned the fire extinguisher at the required height in accordance to NFPA 10. No specific residents were identified to be affected.

K 064
SS=D

NFPA 101 LIFE SAFETY CODE STANDARD

Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6

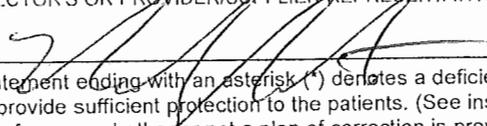
This Standard is not met as evidenced by:
Based on observation, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to mount fire extinguishers at the correct height could hinder response during a fire event. This deficient practice affected staff and vendors in the main Kitchen on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 87 on the day of the survey.

K 064

Other residents

2. On 03/02/2016 an audit was completed throughout the facility by the Maintenance Director to ensure that fire extinguishers are at required height in accordance to NFPA 10, and no other residents were affected; concerns were addressed that time.

Findings include:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3/20/16

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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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLI			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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K 064	Continued From page 1 During the facility tour conducted on March 1, 2016 from approximately 12:45 PM to 3:30 PM, observation of the K-style fire extinguisher located adjacent to the Kitchen main cookline found it was installed at a height of 62-1/2 inches to the top of the extinguisher when measured from the floor. Actual NFPA standard: NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	Systemic Changes 3. On 03/15/2016 the Maintenance Director and Assistant Maintenance Director were re-educated with regards to placing fire extinguishers at a required height in accordance to NFPA 10, by the Regional Senior Maintenance Director. Monitoring 4. Beginning the week of 3/14/2016 the Maintenance Director or designee will complete an audit of the facility weekly for 4 weeks and then monthly for 2 months and quarterly thereafter to validate to ensure that that fire extinguishers are at required height of the top of the fire extinguishers having a gross weight not exceeding 40 lb., are installed and mounted no more than 5 ft. from the floor, or if the fire extinguisher's gross weight was greater than 40 lb. the top of the fire extinguisher was not greater than 3 1/2 feet from the floor as in accordance to Life Safety Standards NFPA 10. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months.		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure the suppression system (Ansul) for the main cookline exhaust hood, was inspected on a semi-annual basis in accordance with NFPA 96. Failure to inspect Ansul systems on a semi-annually could result in fires due to system deficiencies which are normally identified during a semi-annual inspection. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 87 on the day of the survey.	K 069			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016
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K 069 Continued From page 2

Findings include:

During review of facility inspection records conducted on March 1, 2016 from approximately 8:45 AM to 10:30 AM, the inspection records for the Kitchen fire suppression system revealed a gap of ten months between inspections, from December 22, 2014 to October 4, 2015. When asked about the gap, the Maintenance Director stated the vendor had missed the semi-annual cycle due to an installation at another facility.

Actual NFPA standard:

NFPA 96

11.2 Inspection of Fire-Extinguishing Systems.
11.2.1* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons

K 069

The Quality Assurance Performance Improvement Committee will review the results and determine if further interventions are needed at that time. The Maintenance Director will be responsible for monitoring.

Compliance date 03/18/2016

K 069

Specific Residents

1. On 3/1/16 the fire suppression system in the kitchen was checked by an outside contractor and met the requirements of NFPA 96 and per Life Safety Standards. No specific residents were affected.

Other Residents

2. On 03/02/16 an audit of the scheduled inspection was completed by the Maintenance Director of fire suppression system in the kitchen to meet the requirements of NFPA 96 and per Life Safety Standards, and was confirmed to be scheduled to be rechecked in September; no other residents were affected.

Systemic Changes

3. On 03/15/2016 the Maintenance Director and Assistant Maintenance Director were re-educated by the Regional Senior Maintenance Director regarding maintaining a semiannual inspection of the kitchen fire suppression system.

Monitoring

4. Beginning the week of 3/14/2016 the Maintenance Director or designee will complete an audit of the facility weekly for 4 weeks and then monthly for 2 months and quarterly thereafter to ensure that that fire suppression systems are in compliance in accordance with the requirements of NFPA 96 and Life Safety Standards. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed. The Maintenance Director will be responsible for monitoring.

Compliance date 03/18/2016