



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 4045 0038

March 7, 2013

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

Provider #: 135094

Dear Ms. Brutsman:

On **February 22, 2013**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LLC 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/or 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, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should

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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 20, 2013**. Failure to submit an acceptable PoC by **March 20, 2013**, may result in the imposition of civil monetary penalties by **April 9, 2013**.

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

- 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 in place or what systemic change 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. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **March 29, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 29, 2013**. A change in the seriousness of the deficiencies on **March 29, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 29, 2013** includes the following:

Denial of payment for new admissions effective **May 22, 2013**. [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 **August 22, 2013**, 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 Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 22, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

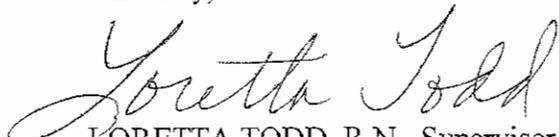
- BFS Letters (06/30/11)

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

This request must be received by **March 20, 2013**. If your request for informal dispute resolution is received after **March 20, 2013**, 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,


LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj
Enclosures

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2013
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLLY	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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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Team Coordinator Karen Marshall, MS, RD, LD Amy Jensen, RN</p> <p>Survey Definitions: BFS = Bureau of Facility Standards MDS = Minimum Data Set assessment CAA = Care Area Assessment DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record BIMS = Brief Interview Mental Status RAI = Resident Assessment Instrument SCSA = Significant Change in Status Assessment IV = Intravenous Q = Every @ = At MRSA = Methicillin-Resistant Staphylococcus Aureus ML/Hr = Milliliters per Hour PEG = Percutaneous Endoscopic Gastrostomy RUE = Right Upper Extremity PICC = Peripherally Inserted Central Catheter R/t = Related To Dx = Diagnosis Meds = Medications MD = Medical Doctor S/S = Signs and Symptoms</p> <p>F 274 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p>	F 000	<p>Preparation and submission of this plan of correction by, Trinity Mission Health & Rehab of Holly, 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 274 1. Resident #1 discharged from the facility on 1/29/13.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wen Roth Administrator</i>	TITLE 3-18-13	(X6) DATE
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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 274	<p>Continued From page 1</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on a public complaint received by the BFS on 2/15/13, record review, and staff interview, it was determined the facility failed to ensure a significant change MDS assessment was completed when Resident #1 returned to the facility from a hospital stay. This affected 1 of 1 (#1) sampled residents. This failure created the potential for unrecognized care needs for the resident. Findings included:</p> <p>The complainant stated an identified resident was admitted to the facility with a feeding tube and staff did not know what to do for the feeding tube.</p> <p>Note: The 4/12 RAI Manual, Chapter 2: Assessments for the RAI, documented, in part: "... A SCSA is appropriate when: ... the resident's condition is not expected to return to baseline within two weeks. ... Emergence of unplanned</p>	F 274	<p>2. On 3/6/13 an audit of the Minimum Data Set (MDS) of residents with a Significant change of condition was completed by the MDS coordinators to determine if a significant change of condition MDS was needed; no other concerns were noted.</p> <p>3. On 2/22/13 the MDS coordinators were re-educated by the Director of Nursing on the Resident Assessment Instrument Guidelines on the criteria for completing a significant change of condition MDS.</p> <p>4. Beginning the week of 3/18/13 the Director of Nursing or designee complete audits of re-admissions and residents with a change of condition, weekly for 4 weeks and monthly for 2 months to ensure that significant change of condition MDS's are completed as required. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Quality Assurance committee will review and determine if further interventions are needed at that time.</p> <p>The Director of Nursing and MDS director are responsible for monitoring and follow-up.</p> <p>Compliance date 3/20/13</p>	

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F 274	<p>Continued From page 2</p> <p>weight loss problem (5% in 30 days or 10% change in 180 days); ... Overall deterioration of resident's condition."</p> <p>1. Resident #1 was originally admitted to the facility on 12/14/12 with multiple diagnoses including sepsis, aspiration pneumonia, and failure to thrive.</p> <p>The resident was discharged to a local hospital on 12/30/12 and readmitted to the facility on 1/5/13 with multiple diagnoses including dysphagia, tube feeding, weight loss, and MRSA in the blood.</p> <p>The resident's 12/21/12 admission MDS coded: - moderately impaired cognitive skills - height 72 inches, weight 143 pounds (#) - no tube feeding - no IV antibiotics</p> <p>The resident's 2012 Yearly Weight Record (YWR) form documented: - 12/15/12 143.4# - 12/26/12 141.6#</p> <p>The resident's 12/30/12 discharge MDS coded return anticipated.</p> <p>The resident's 2013 YWR form documented: - 1/10/13 122.6# - 1/19/13 120.4#</p> <p>NOTE: The resident's YWR forms provided evidence the resident experienced a severe weight loss: 19# (13.4%) in 15 days, from 12/26/12 to 1/10/13.</p>	F 274		

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F 274	Continued From page 3 The resident's 1/5/13 Admission Orders contained, in part: - Vancomycin (Vanco) 1 gram IV q (every) 18 hours MRSA in blood - Jevity @ 75 ml/hr peg tube (with) abd (abdominal) binder in place The resident's Nurses Notes documented, in part: - 1/5/13, "... had PEG tube placed ... Jevity running @ 75 ml/hr. ... PICC line to RUE ... Vanco q 18 [hours] r/t new MRSA Dx in blood ... contact iso [isolation] ..." The resident's Temporary Care Plan included 3 entries related to the resident's 1/5/13 readmission: * Problem PEG Tube, * Problem PICC line, and * Problem MRSA in blood. On 2/21/13 at 2:10 p.m., the survey team informed the MDS Coordinator a significant change MDS assessment should have been completed according to the RAI manual. The MDS Coordinator acknowledged a SCSA should have been completed. On 2/22/13 at 2:00 p.m., the survey team informed the Administrator and the DON of the requirement to complete a SCSA due to the resident's severe weight loss, tube feeding, PICC line, and overall deterioration of condition. The facility did not provide any additional information that resolved the issue.	F 274			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279	F279 1. Resident # 1 was discharged from the facility on 1/29/13.		

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F 279	<p>Continued From page 4 to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on a public complaint received by the BFS on 2/15/13, record review, and staff interview, it was determined the facility failed to ensure the care plan for a resident who was readmitted after a hospital stay addressed the overall deterioration of the resident's condition. This affected 1 of 1 (#1) residents sampled for care plans. This practice had the potential to result in unmet care needs due to lack of direction in the care plan. Findings included:</p> <p>The complainant stated an identified resident had a G-J (Gastrostomy - Jejunum) feeding tube placed while in a local hospital prior to readmission to the facility. The staff did not know</p>	F 279	<p>2. On 2/25/13 the Unit Managers completed an audit of the resident's care plans to ensure care plans were updated and are individualized; no other concerns were noted.</p> <p>3. On 2/25/13 the licensed nurses and the MDS coordinators were re-educated by the Director of Nursing and the Administrator on re-admissions care plans and the need for care plans to reflect the resident's current status.</p> <p>4. Beginning the week of 3/18/13 the Unit Managers or designee will complete audits of care plans weekly for 4 weeks and monthly for 2 months to ensure that care plans are updated to reflect the resident's current status. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Quality Assurance committee will review and determine if further interventions are needed at that time.</p> <p>The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Compliance date 3/20/13</p>	

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F 279	<p>Continued From page 5</p> <p>what to do for the feeding tube. Note: A G tube (Gastrostomy tube) goes into the stomach and a J tube (Jejunum tube) goes into the Jejunum. Resident #1 was originally admitted to the facility on 12/14/12 with multiple diagnoses including sepsis, aspiration pneumonia, and failure to thrive.</p> <p>The resident was discharged to a local hospital on 12/30/12 and readmitted to the facility on 1/5/13 with multiple diagnoses including dysphagia, tube feeding, weight loss, and MRSA in the blood.</p> <p>Resident #1's 12/14/12 admission MDS coded</p> <ul style="list-style-type: none"> - moderately impaired cognitive skills, - two person extensive assistance for bed mobility and transfers, - did not walk, - one person total assistance for locomotion, dressing, and hygiene, - 2 or more person total assistance for toileting and bathing, - one person extensive assistance for eating, - indwelling catheter, - no weight loss, - no tube feeding, - no IV antibiotic administration, and - injection received one day in look back time frame - one Stage 2 pressure ulcer present on admission <p>The resident's 12/14/12 4:45 p.m. Nurse Notes documented, in part: "... has a foley draining ..."</p> <p>The resident's undated Temporary Care Plan</p>	F 279	

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F 279	<p>Continued From page 6 identified:</p> <ul style="list-style-type: none"> * 12/17/12, Problem: St [stage or skin tear] on [right] hip. Goal: S/S of improvement [with no increased] breakdown next 30 d [days]. One approach: Santyl/SilvaSorb [indistinguishable] base clean then Aquacel Ag+ Optifoam Medifix. * 12/17/12, Problem: Irritation/chaff to buttocks. Goal: [decreased episodes of irritation. One approach: Calazime/Bagbalm to buttocks prn [with] care. <p>The resident's 12/30/12 discharge MDS coded return anticipated.</p> <p>On 1/5/13 the resident was readmitted to the facility and the resident's 1/5/13 Nurses Notes documented, in part, "... PEG tube ... Jevity [at] 75 ml/hr ... PICC line ... new MRSA in blood ... contact iso [isolation] ... leg contractures ... puff boots in place ... foley cath [catheter] in place ..."</p> <p>The following 3 problems were added to the resident's care plan on readmission.</p> <ul style="list-style-type: none"> * 1/5/13, Problem: PEG tube. Goal: Will remain patent. Two approaches: abdominal binder in place and food/water/meds per MD orders. * 1/5/13, Problem: PICC. Goal: Will remain patent. One approach: meds/flushes per MD order. * 1/5/13, Problem: MRSA in blood. Goal: Will resolve [after] ABX. One approach: ABX per order, contact iso [isolation]. <p>NOTE: Review of the resident's 2012 and 2013 Yearly Weight Record forms provided evidence the resident lost 19 pounds, severe weight loss in 15 days, from 12/26/12 to 1/10/13. The Care Plan</p>	F 279		

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F 279	<p>Continued From page 7</p> <p>did not identify the problem areas of contact isolation, leg contractures, indwelling catheter, and severe weight loss.</p> <p>NOTE: In addition, Resident #1 was readmitted with a significant change in condition however, a care plan was not developed to address the resident's overall deterioration of condition. Please refer to F274 for details as it related to significant change in status.</p> <p>On 2/21/13 at 2:10 p.m., the surveyor asked the MDS Coordinator about the temporary care plan. The MDS Coordinator stated, "I am not sure who developed the care plan." The MDS Coordinator also stated, "The resident had a Foley catheter when admitted on 12/14/12. I had his care plan to do then he discharged."</p> <p>On 2/21/13 at 2:15 p.m., the surveyor informed the DON that the care plan did not include all the care area needs for the resident. The DON looked at the care plan and did not provide any comment.</p> <p>On 2/22/13 at 2:00 p.m., the Administrator and the DON were informed the care plan did not identify all care areas for the resident. The facility did not provide any additional information that resolved the concern.</p>	F 279		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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</p>	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/22/2013
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLLY		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 8 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a public complaint received by the BFS on 2/15/13, record review, and interview, it was determined the facility failed to ensure nursing staff followed physician orders for: - administering an as needed (PRN) medication (Resident #2). - administering 4 cans of Ensure daily (Resident #1). This affected 2 of 2 (#s 1 & 2) sampled records reviewed. The residents had potential for harm by not receiving ordered supplements and receiving medications outside the parameters set down by physician orders. Findings included: The complainant stated discharge instructions from the hospital included Ensure 4 cans per day. The facility did not have Ensure and a family member had to bring Ensure into the facility for an identified resident.</p> <p>1. Resident #1 was originally admitted to the facility from a local hospital on 12/14/12 and discharged to a local hospital on 12/30/12. Multiple diagnoses included constipation and dementia.</p> <p>The resident's Admission Orders and Interagency/Interfacility Physician Orders both contained an order for, "4 cans Ensure daily/4 cans of Ensure daily" respectively.</p> <p>The resident's December 2012 MAR contained</p>	F 309	<p>F309</p> <p>1. Resident #1 discharged from the facility on 1/29/13. Resident #2 discharged from the facility on 2/09/13.</p> <p>2. On 2/22/13 the Unit Mangers completed an audit of the Medication Administration Records (MAR) to ensure that residents are receiving PRN medications as ordered by the physician; no other concerns were noted.</p> <p>On 3/12 /13 the Unit Managers and Director of Nursing completed an audit of ordered dietary supplements and documentation of delivery of the ordered supplement; no other concerns were noted.</p> <p>3. On 2/25/13 licensed staff were re-educated by the Staff Development Coordinator related to administration of medications ordered by the Physician and documentation of the delivery of dietary supplements.</p>	

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

PRINTED: 03/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2013
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 9</p> <p>an entry in the far right hand column, "1 can Ensure 4 times daily supplement Start Date: 12/14/12." The form also contained spaces for staff to document when the resident received the supplement at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.</p> <p>* On 12/25/12, nursing staff initials were circled for the 12:00 p.m., 4:00 p.m., and 8:00 p.m. administration times. The back of the MAR contained a handwritten entry, "12/25/12, 400 [4:00 p.m.] Ensure ... not available according to kitchen."</p> <p>* 12/25/12 Nurses Notes did not provide evidence the resident was provided with an equivalent substitute for the Ensure that was not available.</p> <p>On 2/21/13 at 2:15 p.m., the surveyor informed the DON the resident did not receive Ensure as ordered by the physician as evidenced by the above identified entries on the resident's December 2012 MAR. The DON stated, "Dietary would have provided a substitution for the Ensure."</p> <p>On 2/22/13 at 2:00 p.m., the Administrator and the DON were informed the resident did not receive Ensure as ordered by the physician.</p> <p>On 2/25/13 at 2:41 p.m., the facility provided a fax of the Admission Orders. The facility identified an area on the Admission Orders, "May substitute generic equivalent for all legend or non-legend medications; Yes." However, the facility did not provide evidence the resident was provided an equivalent substitution for the Ensure that was not available on 12/15/12.</p> <p>2. Resident #2 was admitted to the facility on 1/10/13, with diagnoses of chronic respiratory</p>	F 309	<p>4. Beginning the week of 3/18/13 the Unit Managers or designee will complete audits weekly for 4 weeks and monthly for 2 months to ensure that physicians medication are being administered as ordered and that dietary supplements are delivered and documented as ordered.. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance committee will review and determine if further interventions are needed at that time.</p> <p>The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Compliance date 3/20/13</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/22/2013
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLLY		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686		
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F 309	<p>Continued From page 10 failure, quadriplegia c1 - c4 complete, and respirator dependent.</p> <p>The admission MDS, dated 01/17/13, documented the resident: * was cognitively intact with a BIMS = 15, * was total dependent on staff for ADL care, * received antianxiety and antidepressants daily.</p> <p>The recapitulation physician orders, dated 2/13, documented the resident was to receive ativan 1 mg PRN at bedtime for anxiety, valium 2 mg three times a day for spasms, and ativan 1 mg twice daily PRN do not give within 3 hours of valium for anxiety.</p> <p>Review of the 2/13 MAR the following documentation was found. The resident on 2/8/13, was administered valium 2 mg at 8:00 p.m., The resident was administered ativan 1 mg at 12:15 p.m. and 19:30 [7:30 p.m.], which was within the 3 hour restriction to not receive the ativan.</p> <p>The DON was interviewed on 2/22/13 at 2:00 p.m. No further information was provided.</p>	F 309		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/22/2013
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF HOLL	STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID 83686
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP Team Coordinator Karen Marshall, MS, RD, LD Amy Jensen, RN</p>	C 000	<p>Preparation and submission of this plan of correction by, Trinity Mission Health & Rehab of Holly, 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>	
C 779	<p>02.200.03,a,i Developed from Nursing Assessment</p> <p>i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please refer to F279 as it related to not addressing all the resident's care needs on admission and on readmission.</p>	C 779	<p>Please refer to F279 Plan of Correction</p>	3/20/13
C 788	<p>02.200.03,b,iv Medications, Diet, Treatments as Ordered</p> <p>iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Please refer to F309 as it related to not following physician orders.</p>	C 788	<p>Please refer to F tag 309 Plan of Correction</p> <p>RECEIVED APR 23 2013</p> <p>FACILITY STANDARDS</p>	3/20/13

Bureau of Facility Standards

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

Administrative TITLE

(X6) DATE

4-23-13



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

April 8, 2013

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

Provider #: 135094

Dear Ms. Brutsman:

On **February 22, 2013**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LLC. Karen Marshall, R.D., Arnold Rosling, R.N., Q.M.R.P., Amy Jensen, R.N. conducted the complaint investigation. The investigation for this complaint was conducted in conjunction with another complaint investigation.

Interviews were conducted with the Administrator, the Director of Nursing (DoN) and the Minimum Data Set (MDS) Coordinator.

The identified resident's closed medical record and the medical record at a local hospital, where the resident was transferred were reviewed. The record of a second resident was also reviewed.

The identified resident was originally admitted to the facility on December 14, 2012. The resident discharged to a local hospital on December 30, 2012, and was readmitted to the facility on January 5, 2013. The resident was discharged to a local hospital on January 29, 2013.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005913

ALLEGATION #1:

The complainant stated the discharge instructions from a hospital, for an identified resident

Monica K. Brutsman, Administrator
April 8, 2013
Page 2 of 5

included that the resident was to have four (4) cans of Ensure per day. The facility did not have Ensure. An individual not employed by the facility, provided the facility with Ensure for the identified resident.

FINDINGS:

The resident's December 2012 Admission Orders contained the order for four (4) cans of Ensure daily.

The resident's December 2012 Medication Administration Record (MAR) provided evidence that on December 26, 2012, the resident did not receive Ensure at 12:00 p.m., 4:00 p.m. and 8:00 p.m.

The DoN was interviewed and said, when the facility did not have a dietary supplement such as Ensure, the facility provided a supplement of equal nutritional value. The facility did not provide the survey team with evidence that the resident was provided a supplement of equal nutritional value.

The facility was cited at Quality of Care, federal citation F309 for non-compliance.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated an identified resident weighed one hundred and forty three (143) pounds while at the facility. The resident was admitted to a local hospital, and the weight on admission to the hospital was one hundred and sixteen (116) pounds.

FINDINGS:

The identified resident was admitted to the facility on December 14, 2012.

The resident's 2012 Yearly Weight Record form documented the resident weighed one hundred and forty-one point six (141.6) pounds on December 26, 2012.

The resident was discharged to a local hospital on December 30, 2012, and readmitted to the facility on January 5, 2013.

The resident's 2013 Yearly Weight Record form documented the resident weighed one hundred and twenty-two point six (122.6) pounds on January 10, 2013.

Monica K. Brutsman, Administrator
April 8, 2013
Page 3 of 5

Although the resident lost nineteen (19) pounds from December 26, 2012, to January 10, 2013, the survey team could not determine the resident's weight loss was caused by facility non-compliance because of the ensuing hospital admission.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated approximately nine to eleven days after discharge from a local hospital; the identified resident was choking and coughing. One licensed nurse turned the resident to the side and called for another licensed nurse to assist. The panic caused by the licensed nurses, caused the resident a lot of distress and panic.

FINDINGS:

The identified resident was originally admitted to the facility on December 14, 2012. Review of the resident's nurses notes from December 23, 2012, through December 25, 2012, did not provide evidence the resident was choking and coughing or exhibited signs and symptoms of distress and panic.

The resident was readmitted to the facility on January 5, 2013. Review of the resident's nurses notes from January 14, 2013, through January 16, 2013, did not provide evidence the resident was choking and coughing or exhibited signs and symptoms of distress and panic.

It could not be determined that there was non-compliance related to this issue.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated an identified resident had a feeding tube. A nurse was tugging on the tube, to the point it caused the resident pain. The nurse was questioned about what port to use. The nurse said there was only one port to use.

According to the complainant, after the nurse said there was only one port to use, a family member went to the hospital and obtained pictures of the gastrostomy - jejunum (G - J) tube for the facility. The information was shared with the Administrator, but the next day staff still did not know what to do and said transfer information for the resident was not received from the hospital.

FINDINGS:

Review of the identified resident's nurses notes provided evidence on January 23, 2013, a family member had concerns about the resident's percutaneous endoscopic gastrostomy (PEG) tube and spoke with a nurse. According to the licensed nurse's documentation, there seemed to be confusion about a PEG versus a percutaneous endoscopic jejunostomy (PEJ) tube. The nurse documented the purpose of the different ports of the G-J tube was explained to the family member.

The resident's medical record contained a fax from the hospital to the facility the next day, January 24, 2013, regarding the use of the G-J tube. The information contained in the fax supported the nurse's explanation, the previous day to the family member, for the purpose of the different G-J tube ports.

The resident's medical record did not provide evidence the resident experienced pain due to a nurse tugging on the tube.

However, the facility was cited at Resident Assessment, for non-compliance as indicated:

F279: The facility did not identify and care plan all the care needs for the resident; indwelling catheter on admission, and on readmission indwelling catheter, weight loss and overall deterioration of the resident's condition.

F274: On readmission to the facility, the facility did not identify and complete a significant change of status assessment of the resident. Federal requirements indicated a significant change assessment should have been completed due to the emergence of an unplanned weight loss, overall deterioration of the resident's condition and a condition(s) not expected to return to baseline within two weeks.

CONCLUSIONS:

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

ALLEGATION #5:

The complainant stated an identified resident vomited due to the facility using the wrong ports, and the tube was plugged and displaced. On the same day, the resident was transferred to a local hospital with aspiration pneumonia and dehydration.

FINDINGS:

The identified resident's nurses notes did not provide evidence the resident vomited on the day

Monica K. Brutsman, Administrator
April 8, 2013
Page 5 of 5

the resident was transferred to a local hospital or that the wrong ports were used for the tube feeding.

The nurses notes documented the licensed nurse was unable to unclog the percutaneous endoscopic gastrostomy (PEG) tube, central feeding port and medication port. However, the suction port did flush. The nursing staff contacted the attending physician and an on-call physician. The resident was transferred to a local hospital, per attending physician orders.

The local hospital emergency department report did not provide evidence that the resident was admitted with aspiration pneumonia and dehydration.

The survey team determined the facility complied with federal requirements.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and overlapping.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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The following documents were reviewed:

- Facility Census.
- List of ventilator dependent residents.
- Employee Schedule for February 2013. The schedule included the Respiratory Therapists (RTs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nurse Aides (CNAs) who worked that month.
- List of admissions and discharges for the previous three months.
- Incident and Accident reports for January and February 2013.
- Maintenance records for the ventilator identified as the problem.
- In-service training completed with RT and facility staff on alarms.
- Policy and Procedures were reviewed for care and troubleshooting a ventilator.

Interviews were conducted with the facility's Administrator, Director of Nursing, Respiratory Therapy Supervisor and Staff Development Coordinator. The identified resident's nursing home and the hospital's emergency room (ER) medical records were reviewed.

Monica K. Brutsman, Administrator
April 8, 2013
Page 2 of 3

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005915

ALLEGATION #1:

The complainant stated the resident, who had been total dependent on a ventilator for the last seven years, recently transferred to this facility. The resident told facility staff that the ventilator was not working and had problems several times before February 9, 2013. On February 9th the resident was found unresponsive and the ventilator was not working. The alarms were not working or were turned off so there was no alarm or indication when the machine failed. The resident was transferred to a local hospital and placed on a ventilator. On Monday February 11, 2013, the hospital conducted a test, determined the resident was brain dead and pronounced him dead.

According to the complainant, facility staff told a family member that the alarms were not working so they could not know the ventilator was not functioning. The resident was alert and able to talk with family on February 8, 2013.

FINDINGS:

The resident's medical record did not document a reason why the resident became unresponsive while on the respirator. The resident was having some breathing issues on February 8, 2013, at 10:40 p.m. The RT documented that the resident's oxygen saturation level had dropped to 72%. The RT suctioned the resident and was able to get his saturation level up to 92%. The resident was found unresponsive at 11:55 p.m. and CPR was initiated. The paramedics were called and the resident responded but stopped breathing two more times before getting to the local hospital ER.

The Respiratory Supervisor was interviewed on February 21, 2013, about the allegation that the alarms were not working or turned off. The supervisor gave the surveyors a demonstration of the alarms, showing how difficult it is to immobilize the alarms on the machine that the resident used. The supervisor indicated that the resident's alarms were working. There was no alarm when the resident was found unresponsive because the ventilator was moving air in and out of the resident. The resident and family refused to have the balloon on the tracheostomy tube inflated; as a result, part of the air being pushed into the lungs would bypass the tracheostomy tube. The settings on the ventilator were set at maximum in order to get enough air into the resident's lungs to maintain a saturation level of low 90%. In addition, the paramedics were not able to get a seal on the tracheostomy tube so they pulled it. The paramedics inserted an endotracheal tube and inflated its balloon. Then they were able to bag the resident with success.

Monica K. Brutsman, Administrator

April 8, 2013

Page 3 of 3

On February 4, 2013, one of the RT's did an incident report after he explained the risk versus benefits of a "cuffless trach" being used on the resident. The resident and family both refused to have the cuff inflated.

The ventilator that was used on the resident was reviewed. The machine was purchased on January 25, 2013. The machine had a full diagnostic test run on January 31, 2013, that it passed. The machine was put in service on the resident on February 4, 2013. There was no indication from the every four-hour checks that there was any problem with the machine. It appeared to be functioning appropriately. When interviewed, the RT Supervisor stated that any machine with any indication that it was going to have a problem was immediately traded and had full diagnostic tests run.

The in-service and competencies for the RT's working on February 8, 2013, were reviewed. Both had passed and were signed off to provide care to residents with a ventilator.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj