



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: 7012 1010 0002 0836 1925**

January 30, 2014

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

Provider #: 135094

Dear Ms. Brutsman:

On **January 17, 2014**, a Recertification, Complaint Investigation and State Licensure 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 one that comprises a pattern 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 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 **February 12, 2014**. Failure to submit an acceptable PoC by **February 12, 2014**, may result in the imposition of civil monetary penalties by **March 4, 2014**.

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.

- The administrator must sign and date the first page of both the federal survey report, Form

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 3 of 4

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 **February 21, 2014 (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 **February 21, 2014**. A change in the seriousness of the deficiencies on **February 21, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 21, 2014** includes the following:

Denial of payment for new admissions effective **April 17, 2014**. [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 **July 17, 2014**, 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.

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

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 4 of 4

Regional Office or the State Medicaid Agency beginning on **January 17, 2014** 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:

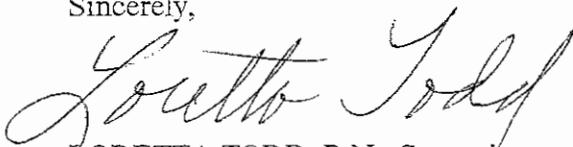
- BFS Letters (06/30/11)

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

This request must be received by **February 12, 2014**. If your request for informal dispute resolution is received after **February 12, 2014**, 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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  135094	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE:  1/17/2014
NAME OF PROVIDER OR SUPPLIER  TRINITY MISSION HEALTH & REHAB OF HOLLY		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 12TH AVENUE ROAD NAMPA, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 281	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on observation, staff interview, record review, facility Medication Administration policy and Standard of Practice review, it was determined the facility failed to provide services that met professional standards for Quality of Care while administering medications. This was true for all residents on the 100 and 200 Halls, and 2 of 4 LN observed administering medications (LN #7 and LN #19). The deficient practice occurred when the LN from each hall was observed to sign they had given medication prior to giving the medication to the resident. Findings include:</p> <ol style="list-style-type: none"> <li>1. Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do."</li> <li>2. The facility's Policy for Medication Administration dated 09/10 recorded:  *Documentation                      "1. The individual who administers the medication dose, records the administration on the resident's MAR following the medication being given."</li> <li>3. On 1/15/14 at 11:24 LN #7 dispensing medications on the 200 Hall, was observed to administer medications to Resident #8, that included:                       -Novolog Flex pen 22 units subcutaneous                      -Geodon 20 mg [milligrams] 1 capsule po[by mouth]                      -Sinemet 25/100 mg 1/2 tablet po                      -Gabapentin 300 mg 1 capsule po                      -Tylenol 325 mg 1 tablet po.                       When the LN had dispensed all the medications she was administering to the resident, she was observed to sign the MAR [Medication Administration Record.] The LN and the Surveyor went into the resident room and the LN administered the medication. The LN was asked if she had signed out the medications prior to giving them to the resident, she stated, "I did." The MAR was checked and the medications had been signed as given.</li> <li>4. On 1/15/14 at 4:05 pm LN #19 administering medications on the 100 Hall, was observed to administer a</li> </ol>		

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

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<p><b>F 281</b></p>	<p>Continued From Page 1</p> <p>medication to Resident #13 that included:</p> <p>-Hydrocodone/Acetaminophen 5/325 mg po., the tablet was crushed and put in pudding.</p> <p>When the LN had dispensed the medication from the package she was observed to sign the MAR. The medication was taken into the room and administered to the resident. When asked if she had signed for giving the medication prior to giving it, she stated "yes."</p> <p>On 1/6/14 at 5:00 pm the Administrator and the DON were informed of the findings. No additional information was provided.</p> <p>F281</p> <ol style="list-style-type: none"> <li>1. On 1-28-14 Residents residing on 100hall and 200 halls were assessed by the Director of Nursing regarding medication administration and no concerns were noted.</li> <li>2. On 1-24-14, the nurse managers completed medication pass audit on 100, 200, 300, 400, 500 halls to ensure that required signing of medication that is prescribed is being followed and no concerns were noted.</li> <li>3. The Licensed Staff were re-educated on 1-15-14, by the Director of Nursing on medication pass and the required signing of medication administration to the resident.</li> <li>4. Beginning the week of 2-17-14 the Nurse Managers will complete 3 audits weekly of medication passes weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure required signing of administration of medication is being followed. 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. The Director of Nursing is responsible for monitoring and follow-up.</li> </ol> <p>Date of compliance 2-17-14</p> <p><i>YMBh</i>      <i>2-7-14</i></p>
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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:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD</b> <b>NAMPA, ID 83686</b>	
(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><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual Federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP, Team Coordinator Bradley Perry, BSW, LSW Lauren Hoard, RN, BSN Susan Gollobit, RN Jana Duncan, RN, MSN</p> <p>The survey team entered the facility on Monday, January 13, 2014 and exited the facility on Friday January 17, 2014.</p> <p>Survey Definitions:</p> <p>ADL = Activities of Daily Living CNA = Certified Nurse Aide DON = Director of Nursing MDS = Minimum Data Set assessment MG = Milligram OT = Occupational Therapy PRN = As needed</p>	F 000	<p><b>Preparation and submission of this plan of correction by, Trinity Mission Health &amp; 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.</b></p> <p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>FEB 10 2014</b></p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p> <p>F164</p>	
F 164 SS=D	<p><b>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</b></p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private</p>	F 164	<p>1. On 1-28-14 the Licensed Social Worker re- assessed resident #8 for concerns related to health information being discussed in a non private setting, and no concerns were noted.</p>	2-7-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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 164	<p>Continued From page 1 room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to protect a resident's personal medical information during an observation. This was true for 1 of 16 residents (#8) sampled for confidentiality of records. This failed practice created the potential to negatively affect the resident's psychosocial well-being. Findings included:  Resident #8 was admitted to the facility on 6/28/13 with multiple diagnoses including congestive heart failure and paralysis agitans.  On 1/13/14 at 11:15 AM, LN #7 went into the resident's room. LN #7 did not close the door to the room and was heard by two surveyors in the hallway discussing the resident's current medical</p>	F 164	<p>2. On 1-20-14 Social Services completed and audit of the facilities common areas and hallways to ensure that resident's privacy was being protected, and no concerns were noted.</p> <p>3. On 1-15-14 the facility staff were re-educated by the Director of Nursing on patient confidentiality and honoring resident's rights to privacy.</p> <p>4. Beginning the week of 2-17-14, Social Services Director or designee will complete weekly audits of common areas and hallways for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that resident's rights to privacy is being honored. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance committee will review and determine if further intervention are needed at this time. The Social Services Director is responsible for monitoring and follow-up.</p> <p><i>Don Jodi</i> Date of Completion 2/17/14 3/5/14 - 8:15 AM All audits will be changed to every week X 2 every 2 weeks X 2 + monthly</p>	2-17-14

*S. Carr*

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F 164	<p>Continued From page 2</p> <p>condition. The resident was lying in his bed which was approximately 10 feet from the door to the hallway. The resident complained to the nurse of a medical symptom he had been having and since the resident had difficulty hearing, the LN spoke to the resident in a loud voice. She then discussed the symptoms and medication he had been taking and treatment plans for the resident.</p> <p>On 1/13/14 at 11:25 AM, LN #7 was interviewed regarding the privacy issue. When asked why the she did not close the door prior to talking with the resident, she stated, "I didn't think about it, I'm sorry...I do have to project my voice a bit."</p> <p>On 1/15/14 at 4:40 PM, the Administrator, the Corporate Nurse Consultant, and Regional Vice-President were notified of the issue. No further information was provided by the facility.</p>	F 164	
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that the interdisciplinary team had evaluated a resident to ensure self administration of medication was safe. This was true for 1 (#20) random resident reviewed for self administration of medication. Medication errors may occur if a resident was not competent to self administer medications. Findings include:</p>	F 176	<p><i>3/5/14 - Resident does &amp; self administer Staff will be retrained to ensure TDT is involved along with Physician &amp; Case</i> 2-17-14</p> <p>1. On 1-28-14 the Assistant Director of Nursing (ADON) reassessed Resident # 20 for concerns related to self administration of a Nebulizer treatment prior to an evaluation of a self administration of medications, and no concerns were noted.</p> <p>2. On 1-23-14 the Unit Manager completed an audit of residents to ensure that self administration of medication assessments had been completed on residents requesting to self administer medications, and there were no concerns noted.</p>

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F 176	<p>Continued From page 3</p> <p>Resident #20 was admitted to the facility on 1/10/14 with diagnoses of acute chronic respiratory failure, depression and gastroesophageal reflux disease.</p> <p>The physician's admission orders dated 1/10/14 documented the resident was to have Albuterol - Ipratropium 2.5. mg - 0.5 mg in 3 ml inhalation solution four times a day.</p> <p>The resident's medical record did not contain documentation the interdisciplinary team had evaluated the resident to ensure self administration of medications was safe.</p> <p>On 1/13/14 at 7:50 a.m. Resident #20 was observed to be doing an Albuterol treatment without nursing supervision. The resident had the mask on her face when first observed then put the mask down while the medication was still coming out of the chamber and sat it on the overbed table.</p> <p>On 1/15/14 at 9:50 a.m. Resident #20 was observed to be doing an Albuterol treatment without nursing supervision. The resident was observed holding the mask to her face without any problems.</p> <p>The DON was interviewed on 1/16/14 at 9:15 a.m. The DON did not have anything to say about self administration of medications.</p>	F 176	<p>3. On 1-20-14 the licensed staff were re-educated by the Director of Nursing related to the need for an assessment prior to self administration of medications and that unless there is an evaluation that the resident has been assessed to be safe to self administer medications, that the licensed nurse will administer the residents' medications and treatments.</p> <p>4. Beginning the week of 2-17-14, the nurse managers will complete 3 audits of medication pass weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that resident's medications are administered as ordered and resident's have been assessed for self administration of medication if indicated. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Quality Assurance committee will review and determine if further intervention are needed at this time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of</p>	F 221	<p><i>Resident #20</i></p>

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F 221	<p>Continued From page 4 discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to ensure residents were free from restraints. The facility failed to:</p> <ul style="list-style-type: none"> <li>- Identify medical symptoms for the use of restraints,</li> <li>- Assess residents for reducing the use of restraints, and</li> <li>- Evaluate residents to assure the least restrictive device was used.</li> </ul> <p>In addition; the facility failed to follow their own policy for evaluating and reducing the use of restraints.</p> <p>The facility was using lap trays and seatbelts to restrain residents in their wheelchairs. This was true for 4 of 16 (#s 4, 6, 9, &amp; 13) sampled residents. There was a potential for harm when residents are restrained, residents could potentially slide down in their chairs and be strangled by the restraint. Findings include:</p> <p>The facility failed to follow their Nursing Policies &amp; Procedures, dated 7/07 for Physical Restraints. "The program shall consist of three approaches to limit the use of physical restraints: restraint prevention; restraint justification; and restraint reduction."</p> <p>Specifically the portion of the procedures the staff failed to follow were:</p> <p>"B. Restraint Evaluation 1. When a physical restraint is deemed medically</p>	F 221	<p style="text-align: right;">2-17-14</p> <p>F 221</p> <p>1. On 1/20/14 Resident #4 was re-assessed by the Director of Nursing for the medical need of a restrictive device and reviewed with the resident's physician and orders were clarified with the physician for the continued medical need of the restrictive device. On 1/20/14 Resident #6 was re-assessed by the Director of Nursing for the medical need of a restrictive device and reviewed with the resident's physician and orders were clarified with the physician for the continued medical need of the restrictive device.</p> <p>On 1/20/14 Resident #9 was re-assessed by the Director of Nursing for the medical need of a restrictive device and reviewed with the resident's physician and orders were clarified with the physician for the continued medical need of the restrictive device.</p> <p>On 1/20/14 Resident #13 was re-assessed by the Director of Nursing for the medical need of a restrictive device and reviewed with the resident's physician and orders were clarified with the physician for the continued medical need of the restrictive device.</p>

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

PRINTED: 01/24/2014  
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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 01/17/2014
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 221	<p>Continued From page 5</p> <p>necessary, the least restrictive device will be used first.</p> <p>2. The interdisciplinary team will complete a Restraint Evaluation Form or answer the following questions regarding continued restraint use:</p> <p>(a) Why is the resident restrained?</p> <p>(b) Is the most appropriate and least restrictive device in use?</p> <p>(c) During what time of day is the restraint(s) used?</p> <p>(d) Where is the resident restrained? (e.g., own room, in bed, in chair)</p> <p>(e) How long is the resident restrained each day?"</p> <p>"C. Restraint Reduction Program</p> <p>1. Residents who have physical restraints in use and are determined to be candidates for restraint reduction will be referred to an interdisciplinary team for assessment.</p> <p>2. Functions of the team.</p> <p>* Education of all facility staff regarding the facility's policy on restraint usage and the various alternatives used for restraint reduction.</p> <p>* Monitor all residents who are currently utilizing a physical restraint to ensure it is a restraint of the least restriction.</p> <p>3. Composition of the committee....</p> <p>4. The team will meet on a weekly basis and review residents currently using a physical restraint:</p> <p>* Each resident will be evaluated by the team on a monthly basis.</p> <p>* The team will identify the need for restraint after direct observation and assessment of the resident.</p> <p>5. The team will target residents for restraint reduction. During each meeting, appropriate candidates should be selected based upon</p>	F 221	<p>2. On 1-20-14, an audit of resident's who have physical restraints was completed by the Director of Nursing, to reassess for the medical need, use of the least restrictive device and the for the continued need of the physical restraint and concerns we're addressed as needed.</p> <p>3. On 1-22-14 nursing staff and nurse manager's were re-educated by the Director of Nursing on the requirement of the assessment of the medical need, the evaluation of the least restrictive device and the reassessment of the continued need of the restrictive device. On 2-7-14 the nurse managers were re-educated on the current Restraint Policy by the Administrator.</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 6</p> <p>physical and mental condition and the ability to succeed in a reduction program..."</p> <p>1. Resident #6 was admitted to the facility on 8/23/13 with diagnoses of senile dementia uncomplicated, failure to thrive, depressive disorder, and generalized muscle weakness.</p> <p>The 10/19/13 quarterly MDS assessment documented the resident:</p> <ul style="list-style-type: none"> <li>- was cognitively impaired with short and long term memory problems,</li> <li>- was moderately impaired decision making skills,</li> <li>- required extensive assistance of one to two staff for transfers, dressing, eating, personal hygiene and bathing.</li> <li>- was in a chair that prevents rising.</li> </ul> <p>The 1/14 physicians' recapitulation orders documented, "10/3/13, Sentinal [sic] belt to w[heel]/chair [related to] need for assist/no safety awareness. Check [every] 30 min[utes] release [every] 2 [hours] for cares and repositioning."</p> <p>The 9/5/13 care plan problem of, "Falls: I am at risk for falls [related to] generalized weakness, use of psychotropic meds, altered gait, history of falls." One of the interventions was: "10/3/13 Sentinal [sic] Belt to [wheelchair] as usual cue to get assist. [Check] [every] 30 min [and] release [every] 2 [hours with] cares."</p> <p>A "Restraint Evaluation and Approval by Resident or Surrogate" was completed on 10/3/13 and documented, "Sentinel belt to help maintain safe seating. Poor safety awareness/dementia unable to release. check [every] 30 min/Release [every] 2 [hours]." The evaluation further documented, "Sentinel belt to maintain seated position, reduce</p>	F 221	<p>4. Beginning the week of 2-17-14 weekly audits of a physical restraint will be competed by the Director of Nursing or designee for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that the resident has been assessed for the medical need, the use of the least restrictive device and the continued need of the restrictive device per restraint policy. A report will be submitted to the Quality Assurance committee monthly for 3 months. The Quality Assurance committee will review and determine if further intervention are needed at this time. The Director of Nursing will be responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 7</p> <p>injury risk." and "It will be used for safety/position during time in chair..."</p> <p>A "Quarterly Physical Restraint Review" was completed on 10/29/13 and documented, "Sentinel belt to [wheelchair] due to high risk of falls and poor safety awareness. (no siderails) has concave mattress, low bed and mat beside bed. Resident was assessed for safety [with] these devices and deemed safe."</p> <p>The resident was observed on multiple occasions during the survey to be in her wheelchair and the seat belt in place. Some date and times of the observations were: on 1/13/14 at 10:30 a.m. in her room; on 1/13/14 at 1:35 p.m. in her room; on 1/13/14 at 3:15 p.m. at activities; on 1/14/14 at 1:20 p.m., 2:30 p.m., and 3:15 p.m. in her room; [Note: The 3:15 p.m. observation the resident had slid down and the seatbelt was tight on her abdomen and the resident appeared uncomfortable.] and on 1/16/14 at 9:10 a.m. and 10:55 a.m. in her room.</p> <p>The residents medical record was reviewed and it was determined the facility failed to:</p> <ul style="list-style-type: none"> <li>- identify the medical symptom for the restraint,</li> <li>- evaluate the resident for reduction of the restraint on a monthly basis as per the facility policy,</li> <li>- follow the facility policy and procedures for restraints, specifically, the facility did not address the questions in the policy about continued use of the restraint.</li> </ul> <p>The DON was interviewed on 1/16/14 about the use of restraints for this resident. The DON indicated the restraint evaluation was completed on the resident but did not elaborate on medical</p>	F 221		

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

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F 221	<p>Continued From page 8</p> <p>necessity and reduction. The DON provided the facility policy see the introduction.</p> <p>2. Resident #13 was admitted to the facility on 12/27/13, with diagnoses of paralysis agitans and dementia with behavior disturbance.</p> <p>The 1/3/14 admission MDS assessment documented the resident was:</p> <ul style="list-style-type: none"> <li>- severely cognitively impaired,</li> <li>- required extensive assistance with transfers, dressing, eating, and personal hygiene,</li> <li>- was restrained in a chair that prevents rising.</li> </ul> <p>The January 2014 physician recapitulation orders documented, "12/27/13 - lap tray to wheelchair."</p> <p>The initial care plan [Not Dated] documented a problem of, "Restraint: I am at risk for injury due to my need for a chair that prevents rising." The care plan Interventions [Not Dated] documented:</p> <ul style="list-style-type: none"> <li>* Check lap buddy every 30 minutes and remove every two hours for re-positioning.</li> <li>* Check my device daily to make sure it is in good condition.</li> <li>* Provide me with diversional activities.</li> <li>* Remove my device during supervised activities.</li> <li>* Watch for signs of frustration related to use of the lab buddy e.g. increased agitation, restlessness. Report to nurse if observed."</li> </ul> <p>A "Restraint Evaluation and Approval by Resident or Surrogate" was completed on 12/27/13 and documented, "Lap tray, assists [with] positioning in [wheelchair], reminds to use call light for assist." The evaluation further documented, "Lap tray to w/c to assist with positioning and to remind resident to get assist for transfers. Unable to self release..." and "It will be used for</p>	F 221		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 221	<p>Continued From page 9 safety/position during time in chair..."</p> <p>The resident was observed on multiple occasions the last two days of the survey to be in his wheelchair and the lap tray in place. The dates and time of the observations were; 1/15/14 at 10:30 a.m. in the activity area, 1/15/14 at 1:30 p.m. in his room, and 1/16/14 at 9:10 a.m. and 10:55 a.m. in his room.</p> <p>The residents medical record was reviewed and it was determined the facility failed to:</p> <ul style="list-style-type: none"> <li>- identify the medical symptom for the restraint,</li> <li>- assess for least restrictive alternatives to the restraint,</li> <li>- evaluate monthly for reduction of the restraint as specified in the facility policy.</li> <li>- follow the facility policy and procedures for restraints, specifically, the facility did not address the questions in the policy about continued use of the restraint.</li> </ul> <p>The DON was interviewed on 1/16/14 at 9:15 p.m. and confirmed the resident could not remove the lap tray. The DON indicated the restraint evaluation was completed on the resident but did not elaborate on medical necessity and reduction.</p>	F 221		
	<p>3. Resident #9 was admitted to the facility on 7/11/13 with multiple diagnoses which included dementia with behavioral disturbances, bipolar disorder and muscular wasting.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 10/10/13, documented in part: * Unable to complete interview for cognitive patterns;</p>			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>* Moderately impaired with daily decision making, cues/supervision required;</li> <li>* Inattention, disorganized thinking and psychomotor retardation that comes and goes and changes in severity;</li> <li>* Extensive assistance needed with 2 or more people for bed mobility, transfers, and toilet use;</li> <li>* Extensive assistance needed with 1 person for dressing, eating, and personal hygiene;</li> <li>* One fall since admission with no injury and one fall since admission with minor injury; and,</li> <li>* Restraints in chair/out of chair to prevent rising.</li> </ul> <p>The Care Plan for Resident #9, dated 7/26/13, documented in part:</p> <ul style="list-style-type: none"> <li>* Problem/Need - "FALLS: I am at risk for falls r/t (related to) hx (history) of falls, poor safety awareness, altered gait and dementia;" and,</li> <li>* Approaches - "Sentinle [sic] Belt to w/c [wheelchair] 7/11/13."</li> </ul> <p>Telephone Physician Orders for Resident #9 documented in part:</p> <ul style="list-style-type: none"> <li>* 7/11/13 - "Low bed, No siderails, mat on floor, concave mattress: safety. Sentinale [sic] belt to W/C [wheelchair] - unsafe transfers...;" and,</li> <li>* 9/13/13 - "Clarification: Check q [every] 30 min[utes] and release q 2 [hours] for cares and repositioning for sentinale belt to W/C."</li> </ul> <p>Note: The Physician's Orders did not document a diagnosis or medical justification for the restraint.</p> <p>A Restraint Evaluation and Approval by Resident or Surrogate form for Resident #9, dated 7/11/13, documented in part:</p> <ul style="list-style-type: none"> <li>* Self-release belt - "Sentinel belt for positioning, fall risk r/t [related to] dementia [with] poor safety awareness;" and,</li> <li>* "An evaluation was performed on 7/11/13..."</li> </ul>	F 221		

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

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FORM APPROVED  
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F 221	<p>Continued From page 11</p> <p>which revealed the following type of restraint is recommended: Sentinel belt to maintain safe seating/ low bed [with] mat on floor, concave mattress to show EOB [Edge of Bed], non-restrictive doesn't prevent movement."</p> <p>A Restraint Clarification Form for Resident #9 provided a questionnaire with True or False questions which included the following:          * "The use of the device still allows freedom of movement and/or normal access to their body?" was answered as false;          Note: This question contradicts the aforementioned statement on the Restraint Evaluation and Approval form.          * "The least/restrictive/most dignified device is being used?..." was answered as true;          * "Device will not interfere with resident's quality of life" was answered as true;          * "Device will not cause an increase in behaviors/agitation" was answered as true;          * "There is no indication that the resident will climb out or over the device" was answered as true; and,          * "(IF resident has no purposeful movement). The resident is unable to make conscious attempt to exit device" was answered as true.</p>	F 221		
	<p>The Form also asked the question, "Is the device medically necessary? If so why?" The documented answer was, "High fall risk" with a diagnosis of "dementia [with] psychosis." Benefits of the device were documented as, "Sentinel belt. To alert staff to self-transfers resulting in high probability of falls. (NOTE: This contradicted the statement above that the resident had no purposeful movement.) Resident has severe cognitive impairment related to dementia." The Form was signed by the resident's surrogate on 10/16/13.</p>			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	Continued From page 12  Resident #9 was observed on: * 1/13/14 at 11:17 a.m., the resident was in his room sitting in his wheelchair with the sentinel belt in place. The resident's wasteband to his pants were just above the knees as he progressively wiggled them down while seated. The ADON walked past the room but did not observe the resident. 2 CNA's walked past the room but did not observe the resident; * 1/13/14 at 12:25 p.m., the resident was in the Rockin' Rooster dining room in his wheelchair with the sentinel belt in place. The resident repeatedly slid himself down in the wheelchair while at the dining room table; * 1/13/14 at 12:41 p.m., the resident was in his room sitting in his wheelchair with the sentinel belt in place; * 1/14/14 at 4:35 p.m., the resident in his room sitting in his wheelchair with the sentinel belt in place; and, * 1/14/14 at 5:35 p.m., the resident was in the Rockin' Rooster dining room in his wheelchair with the sentinel belt in place.	F 221		
	On 1/15/14 at 11:10 a.m., the DON was interviewed about Resident #9's restraint. When asked which medical symptom led to the consideration of the use of the restraint the DON said the resident came from a different nursing home with a sitter and they had reduced the sitter to just at night before transfer. The DON added the resident was a, "Really high fall risk" and was declining after admission. When asked why the resident needed the restraint, the DON stated, "[The] sentinel belt [was] for positioning in [the] chair" and added the resident, "Can't release it." The DON was asked how the facility determined the seat belt to be the most appropriate device.			

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

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F 221	<p>Continued From page 13</p> <p>She said it was based on the admission assessment, resident history and notes from the previous facility. When asked why the facility had not attempted the use of a 1 on 1 sitter, the DON responded, "He's never needed that." The DON was asked if the causes of any medical symptoms could be eliminated or reduced, she stated, "I do not recall" and added she had not seen the resident without the seat belt to determine if it was the most appropriate. The DON was asked if OT [Occupational Therapy] or PT [Physical Therapy] had assessed the device for Resident #9, she stated, "I doubt it." When asked if alternatives had been attempted, the DON said the facility tried to use a Meri-walker but it had failed and PT had assessed for the use of the Meri-Walker.</p> <p>The Physical Therapy Plan of Care for Resident #9, dated 8/17/13, documented in part: * "Reason for Referral: Pt is referred to Physical Therapy for, "PT Eval[uation] and Treat[ment] for using Meri-walker or for w/c positioning - proper positioning... Pt has a tendency to extend his body and slide under his seat belt alarm... Long Term Goal(s): The patient will improve gait ability with a Meri-Walker on even surfaces to stand by assistance (close enough to reach patient if assist needed) in order to... reduce burden of care on support staff."</p> <p>An Incident Report for Resident #9, dated 8/10/13, documented in part: * "Time of Incident: 1445 [2:45 p.m.];" * "Location if Incident: Resident Room," * "Nature of Injury: Fall;" * Incident Description: "What was the position of the resident? lying on [left] side on floor [.] What was mental state of resident? Confused [.] What</p>	F 221			

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

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F 221	<p>Continued From page 14</p> <p>did the resident say happened? "It was time.""</p> <p>An additional Investigation of Incident/Accident report for Resident #9, dated 8/10/13, documented in part:</p> <p>* "If known, what CAUSED this injury / incident? [Right] W/C arm was gone. It was found under some blankets. Sentenyl [sic] belt was still together. It appears that he may had slithered from under the belt because it was very loose. Res[ident] had losened the belt;" and,</p> <p>* "What was done during or immediately after this incident to protect the resident from further injury or risk of injury and to prevent future recurrences of this incident? Put arms back 'on'. When resident was placed back in chair for dinner, sentenyl [sic] belt back on [with] 2 fingers width from abdomen. PT eval[uation] for Meriwalker [sic] or more appropriate seating."</p> <p>On 1/21/14 additional documentation was provided by the facility via fax for Resident #9 which documented:</p> <p>* "#9- [Resident's initials]- Resident has had Sentinel belt since admission 7/11/13;"</p> <p>* "8/7/13- Merry walker attempted and failed;" and,</p> <p>* " Medical evaluation on admission showed that he was requiring a 24hr [hour] sitter at his previous SNF [Skilled Nursing Facility] r/t [related to] dementia [with] poor safety awareness and would attempt to self transfer prior to the staff reaching the door to leave the room. Res[ident] is on haspice services and was declining at the time of transfer, getting up less, eating less etc. Facility chose to continue [with] the low bed as the previous facility had done to decrease risk for injury [with] self transfer attempts. Also sentinel belt to assist [with] positioning in w/c to increase</p>	F 221		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 221	<p>Continued From page 15</p> <p>independence in w/c and reduce need for intrusive sitters. Therapy services were not used at time to transfer r/t hospice status. Therapy was brought on to look at merry walker safety to attempt more independence [with] ambulation. This was a failed attempt r/t Res[ident] was able to sit down on the floor while in the merry walker on the first day of use (8/17/13)..."</p> <p>The additional information did not resolve the restraint issue.</p> <p>4. Resident #4 was admitted on 1/4/13 with multiple diagnoses including hypertension, retention of urine, and dementia.</p> <p>The most recent quarterly MDS assessment, dated 11/7/13, documented the resident:</p> <ul style="list-style-type: none"> <li>- had short and long term memory problems;</li> <li>-had severely impaired decision making skills;</li> <li>-was totally dependent for bed mobility, transfers, dressing, personal hygiene and bathing;</li> <li>-had a restraint in his chair to prevent rising.</li> </ul>	F 221		
	<p>The resident's Physical Restraints care plan, with problem onset date of 1/23/13, documented the resident had a lap tray and an approach was to, "...change my position every 30 minutes and remove lap tray q [every] 2 hours and prn."</p> <p>The resident's Falls care plan, documented an approach on 1/7/13, "Lap tray to w/c [wheelchair] for positioning."</p> <p>The resident was observed on:</p> <ul style="list-style-type: none"> <li>-1/13/14 at 1:45 PM in his room with the lap tray</li> </ul>			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 16</p> <p>in place waiting to be laid down in bed; -1/14/14 at 11:25 AM in his room with the lap tray in place; 1/14/14 at 3:53 PM in his room with the lap tray in place; 1/14/14 at 5:37 PM in the dining room with the lap tray in place; 1/14/14 at 5:45 PM in the dining room with the lap tray removed in order for the resident to eat.</p> <p>The resident's January 2014 Physician Orders documented an order dated 1/7/13 as, "Lap tray to w[heel]/chair R/T [related to] no safety awareness..." Note: The Physician Orders did not document a diagnosis or medical justification for the restraint.</p> <p>The resident's Restraint Evaluation And Approval By Resident Or Surrogate documented on 1/4/13 and discontinued on 1/7/13, "Lap buddy to w/c for positioning and poor safety awareness." On 1/7/13 the form documented, "Lap tray R/T poor trunk control and positioning. Restricts transfers."</p> <p>The resident's OT Daily Treatment Note documented on 1/10/13 and 1/11/13, "Pt [patient] seen for trunk strengthening activities to improve wheelchair positioning."</p> <p>The resident's Quarterly Physical Restraint Review documented the following: -6/21/13, Res[ident] has lap tray to help prevent falls as has [sic] no safety awareness; -8/20/13, Continue [with] lap tray to help prevent falling out of w/c as has [sic] no safety awareness; -11/12/13, Continue [with] above restraints." Note: The Quarterly Restraint Reviews did not address the resident's poor trunk control or</p>	F 221		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	Continued From page 17 positioning as identified by the initial evaluation and occupational therapy notes. There were also no attempts made to reduce the restraint usage with a less restrictive device.  On 1/16/14 at 10:15 AM, the DNS was interviewed regarding the resident's restraint. When asked about the lap tray and if the resident could remove it on his own, she stated, "He can not take the tray off." When asked if the Quarterly Physical Restraint Review was the facility's evaluation form for restraints, she stated, "Yes, these are our evaluation forms." When asked if the resident had been reassessed for a least restrictive restraint like the lap buddy, she said the facility had not tried to use the lap buddy again.  On 1/16/14 at 4:30 PM, the Administrator and DNS were informed of the restraint issue.  On 1/21/14 at 3:51 PM, additional information was provided by the facility via fax regarding the lap tray issue, however, the information did not resolve the concern.	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to maintain residents'	F 241		

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

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F 241	<p>Continued From page 18</p> <p>dignity by exposing their buttocks in the hallway of the facility and when a staff member yelled to residents across a dining room. This was true for 2 of 3 (#21 &amp; 22) random residents seen in shower chairs in the facility hallway and was true for 5 of 5 (#s' 25-29) random residents dining in the Royal Fork dining room and all other residents observed dining. This created the potential for a negative effect on the residents' self-esteem. Findings included:</p> <p>1. On 1/14/14 at 10:50 AM, CNA #10 &amp; CNA #11 were observed wheeling Resident #21 in a shower chair down the hall and into the Four Seasons Spa (shower room). The resident sat upright and his body was covered by a white blanket. When viewed from behind the chair, two surveyors could see an approximately six inch gap between the back support and the seat of the shower chair, where the resident's right and left naked buttocks could be seen.</p> <p>On 1/14/14 at approximately 10:55 AM, CNA #10 was interviewed regarding the observation. When asked if the resident was naked underneath the blanket, she said he was and stated, "That is why they covered him up." When asked the shower process, she said residents normally only have the option of being transferred to the shower room wearing a hospital type gown, however, Resident #21 had soiled his gown prior to the transfer, which is why he was naked.</p> <p>On 1/14/14 at 11:00 AM the resident was brought out of the shower room in the same shower chair, but was covered entirely by a blanket, except for his head.</p> <p>2. On 1/14/14 at 11:02 AM, CNA #11 was</p>	F 241	<p>F241</p> <p><i>3/5/14 DON stated #22 should be #20 of Case 2/7-14</i></p> <p>1. On 1/15/14 Resident #20 was reassessed by the Administrator for dignity related positioning and for privacy while being transported to and from the shower in the shower chair, and no concerns were noted. On 1-28-14 Social Services reassessed the resident for concerns related to resident being transported in the hall in the shower chair and no concerns were noted.</p> <p>On 1/15/14 Resident # 21 was reassessed by the Administrator for positioning and privacy while being transported to and from the shower room, and no concerns were noted. On 1/28/14 Social Services reassessed the resident for concerns related to resident being transported in the hall in the shower chair and no concerns were noted.</p> <p>On 1/24/14 Resident # 22 was reassessed by the Director of Nursing (DON) related to requesting of meal preferences being asked in front of other staff and residents and no concerns were noted. On 1-28-14 Social Services reassessed the resident for concerns related to staff requesting meal preferences in front of other staff and residents and no concerns were noted.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 19</p> <p>observed wheeling Resident #22 out of the Four Seasons Spa (shower room), down the hall, and into his room in a reclined shower chair with a blanket covering him. The surveyor could see a gap in between the blanket and the shower chair, which exposed approximately one foot of the residents lower back and some of his right buttocks.</p> <p>On 1/14/14 at 11:20 AM, CNA #11 was interviewed regarding the observation and she said the resident had been naked underneath the blanket.</p> <p>3. On 1/13/13 at 08:22 am the Royal Fork Dining room was observed for the breakfast meal. CNA #16 and #17 were setting up the tables and serving drinks. There were 16 residents seated at the tables. At 8:29 am the food containers arrived and were placed in the steam table by DE#18 [Dietary Employee]. DE#18 was serving the food, and called out from the cooking area across the room, "[Resident #20] what kind of eggs do you want this morning," then called out the type of eggs she was serving. Resident #20 replied, "that's a good question." The DE #18 left the cooking area. When she returned, she was putting on gloves and called out, "Ok boys and girls are we ready." The DE #18 continued with serving the hall trays. When she had finished with the hall trays she began serving the residents in the dining room. The DE #18 called across the room, "OK [Resident #20] I don't have a ticket for you, but will go ahead." Next, the DE #18 called out to the CNA's, "I won't have a ticket for [Resident #20.]" The DE #18 called out across the room, "[Resident #25's name] your usual," the resident replied, "where's my hot cereal," the DE #18 replied loudly, "you didn't get your oatmeal," the resident replied, "No," the DE #18 replied</p>	F 241	<p>On 1/24/14 Resident #25- was reassessed by the DON related to requesting of meal preferences being asked in front of other staff and residents and no concerns were noted. On 1-28-14 Social Services reassessed the resident for concerns related to staff requesting meal preferences in front of other staff and residents and no concerns were noted.</p> <p>On 1/24/14 Resident #26- was reassessed by the DON related to requesting of meal preferences being asked in front of other staff and residents and no concerns were noted. On 1/28/14 Social Services reassessed the resident for concerns related to staff requesting meal preferences in front of other staff and residents and no concerns were noted.</p> <p>On 1/24/14 Resident #27- was reassessed by the DON related to requesting of meal preferences being asked in front of other staff and residents and no concerns were noted. On 1-28-14 Social Services reassessed the resident for concerns related to staff requesting meal preferences in front of other staff and residents and no concerns were noted.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 20 loudly, "ok." The DE #18 continued to serve trays and called out across the room "[Resident # 26's name] I don't have sausage this morning, eggs ok."  On 1/13/14 at 12:40 pm the Royal Fork dining room was observed for the lunch meal. CNA #16 and #17 were serving drinks, and passing the trays. There were 19 residents present at the tables. DE #18 was serving the trays. The DE #18 called across the room to the CNA's who were amongst the residents, "OK I am ready for trays, is there a divider plate out there for [Resident #28] and [Resident #29]. They keep forgetting to send out [Resident #28's]." The DE #18 continued to serve the trays. [Resident #25] called out asking for more corn, the DE called across the room to the resident, "yes, I suppose you can," the resident replied, "thank you," the DE #18 replied loudly, "you are very welcome." The DE #18 continued to serve the trays. Resident #25 called out for more corn, the DE #18 replied loudly, "I gave you a little bowl of it." Another staff member in the room replied loudly, "it went to someone else." The DE #18 replied loudly, "Ok, well I guess yours went to someone else." After serving up another bowl of corn the DE #18 called out, "Ok this bowl is [Resident #25's]." The DE #18 continued to serve the trays, and called out, [Resident #28] you want rice or mashed potatoes." When the DE #18 had finished serving the trays she called out, "Ok, did I miss anybody." It was brought to the DE #18 attention that she missed Resident #27. The DE #18 called across the room to the resident, "Oh [Resident #27] I did, do you want want Enchiladas or [surveyor was not able to understand what the DE said the second choice was] rice or mashed potatoes." When the DE #18 had completed	F 241	On 1/24/14 Resident #28- was reassessed by the DON related to requesting of meal preferences being asked in front of other staff and residents and no concerns were noted. On 1-28-14 Social Services reassessed the resident for concerns related to staff requesting meal preferences in front of other staff and residents and no concerns were noted. On 1/24/14 Resident #29- was reassessed by the DON related to requesting of meal preferences being asked in front of other staff and residents and no concerns were noted. On 1-28-14 Social Services reassessed the resident for concerns related to staff requesting meal preferences in front of other staff and residents and no concerns were noted.  2. On 1-24-14 the Administrator completed an audit of facility residents while being transported to and from the shower rooms and no concerns were noted. On 1-24-14 the Registered Dietician completed an audit of dining meal services  and honoring resident's privacy and dignity, and no concerns were noted.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 21 serving the dining room trays she left the cooking area and went into the small side room. When DE #18 came out of the room she called out, "anybody need anything else," Resident #25 called back she did, the DE #18 replied loudly, "what you need [Resident #25]", the resident replied, "fruit," the DE #18 replied loudly to the resident, "she is going to pass it around shortly. Need a peanut butter and jelly sandwich [Resident #28.]"  On 1/16/14 at 2:19 pm the CDM was interviewed about the concerns with the noise level and the DE #18 calling out loudly to the residents and staff in the Fork Dining Room. When asked if she was ok with what was observed, the CDM stated, "no, the cook should have the CNA go and speak with the resident, especially if they are hard of hearing." When the CDM was asked about the statement made by the cook, "here we go boys and girls" and providing a homelike environment, she stated "I see what you are saying."  On 1/17/14 at 10:00 am while verifying the names of the residents in the Fork Dining room with the CDM, she stated Resident #27 was on a one week trial basis in the Fork dining room to see how she would do.	F 241	3. The shower aides and nursing staff were re-educated on 1-15-14 by the Director of Nursing on draping and covering of resident to provide privacy and to maintain dignity while being transported to and from their showers. The nursing and dietary staff were re-educated on 1/24/14 by the Dietary Manager and the Administrator regarding conversations in the dining room and honoring resident's privacy and dignity during the meal services.  4. Beginning the week of 2-17-14 the Administrator, the Dietary Manager or designee will complete 3 audits of staff transporting resident to the shower rooms and meal service in the dining room weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that resident's privacy and dignity is being honored while being transported to and from showers and during meal services. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Administrator is responsible for monitoring and follow-up.  Date of compliance 2/17/14	2-17-14	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248			

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

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F 248	<p>Continued From page 22 the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and record review it was determined the facility failed to ensure 1of 16 sampled residents (Resident #11) was taken to activies that the resident enjoyed. The deficient practice had the potential for more than minimal harm in mental and psychosocial wellbeing, when the resident was not assisted to two music activites, and the blinds in her room were left closed. Findings include:</p> <p>Resident #11 was readmitted to the facility on 7/26/13 with diagnoses that included cerebral embolism with infarct, hemiplegia, muscle weakness.</p> <p>The resident's Reentry MDS dated 8/4/13 and Quarterly dated 12/29/13, recorded:</p> <p>*BIMS score: 8/4/13 -12 and 12/29/13 -10 Cognition moderately intact</p>	F 248	<p>F248</p> <ol style="list-style-type: none"> <li>1. On 1-28-14 resident #11 was reassessed by the Activity Director, regarding activities and preferences, and no concerns were noted. On 1-28-14 Social Services reassessed resident # 11 regarding her choices being honored, and no concerns were noted.</li> <li>2. On 1-29-14 the Activity Director audited resident's activity preferences to ensure that their activity preferences of their choosing was honored, no concerns were noted.</li> <li>3. On 1-20-14 the facility staff was re-educated on honoring activity preferences and to invite residents to attend activities of there choosing by the Director of Nursing.</li> </ol>	2/17/14
	<p>*Bed Mobility: Both dates- Total assist 2 persons physical assist</p> <p>*Locomotion off unit: Both dates- Total assist 1 person assist</p> <p>*Preferences for Customary Routine and Activities: 8/4/13 - Res.[resident] interview: listen to music- Very important. - Res. interview: do favorite activities- Very important</p>			

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F 248	<p>Continued From page 23</p> <p>The Resident's Activity Assessment dated 7/26/13, recorded:</p> <ul style="list-style-type: none"> <li>- Activity Preferences: "I enjoy listening to music" was checked.</li> <li>- Give explanation of what item was checked above: "[Resident's name] Enjoys musicals spa being [with] family."</li> </ul> <p>The resident's Activities Progress Notes dated 12/10/13, recorded:</p> <ul style="list-style-type: none"> <li>- "[Resident's name] attends activities when she chooses. She enjoys musicals, rock n RNA [and] bible study."</li> </ul> <p>The resident's Social Progress Notes dated 10/23/13, recorded:</p> <ul style="list-style-type: none"> <li>- "Care conference held with family this afternoon." "[Resident's name] will attend activities of choice when OOB[out of bed] during the day although she will often request to lay down after meals. Family state they feel she is often requesting to lay down after meals to be cleaned up after an incontinent episode and does not think to request to get right back up. Family request that staff lay [resident's name] down after meals to assist her in getting cleaned up then remind her of any late morning/afternoon activities asking her if she would like to get back up to "listen to the live music" "play ball" "paint pumpkins", etc-specifying the particular activity to remind/encourage her to attend more activities she would enjoy instead of being in bed." "Family ask that staff request to open [Resident's name] blinds for her if they notice they are closed during the day as [Resident's name] moved to a window bed to be able to see the outdoors and seeing outside is a factor that assists in</li> </ul>	F 248	<p>4. Beginning the week of 2-17-14 the Activity Director or designee will complete 3 audits of resident's choices to participate in activities of their choosing weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure their activity choices are being honored. 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. The Activity Director is responsible for on monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>	2-17-14

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 01/17/2014
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F 248	Continued From page 24 improving/maintaining her mood." "[Resident's name] reports she is okay with all family suggestions communicated during care conference."  The resident's Care plan dated Admitted 7/26/13, recorded:  *Problem: Psychosocial Wellbeing/Mood: Potential alteration in feelings of well-being related to decline in health resulting in LTC[Long Term Care] placement and life losses.  *Approaches: -Encourage [Residents name] to attend activities of choice to increase socialization. -[Resident's name] enjoys attending the musicals. Please remind [and] encourage [Resident's name] to attend. 10/23/13 -Please open [Resident's name] blinds for her if noticed they are closed during the day.  *Problem: Activity: Diversional Activity Deficit/r/t/cerebral Embolism (with) infroct [sic].  *Approaches: -Activities will assist with OOR[out of room] visits/acts[activities] upon request.  *Problem: Cognition; Memory, Impaired r/t disease processes evidenced by confusion, decision making deficit.  -Provide activity calendar in room and provide assistance with activity selections.  The resident's Daily Care Guide dated 12/29/13, recorded;	F 248		

*3/5/14  
Don stated CP for activities will be reviewed by activity director to include resident choices & initiate request but staff will be responsible ask D Case*

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

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F 248	<p>Continued From page 25</p> <p>-[Resident's name] enjoys Rock N RNA and musicals. Please encourage [Resident's] to attend these activities per family request.</p> <p>On 1/13/14 at 2:10 pm the resident was observed to be in bed, awake. She was asked if staff had invited her to the activity. The resident stated "No, I don't think so. What is it?" When she was told it was Cruizin something, the resident stated, "Oh, ok I want to go, they are a good group." Resident was encouraged to use her call light to get staff. CNA #1 came in to help the resident. The resident told her she wanted to go to the activity. During the cares for the resident CNA #1 stated, "hope its not too late for the music." At 2:32 pm the resident was wheeled in her wheelchair to the activity. The activity continued til 3:17 pm. Throughout the activity the resident was observed to be patting her right hand on her right leg to the beat of the music and was observed to sing along. [NOTE: The music had started at 2:00 pm and the resident had missed 32 minutes of the activity.]</p> <p>On 1/14/14 at 5:20 pm the resident was up in her wheelchair in her room. When asked if she liked music and had she attended the music activity in the morning, the resident stated, "What was it?" "Yeh I like to go to the music and I like to go to ball too." She further stated "I did not get asked to go to the music today. I went to ball exercise today."</p> <p>On 1/15/14 at 12:47 pm the resident was up in her wheelchair in her room sitting beside her bed. The room was dark and the blinds were closed. When asked if she liked the blinds open, the resident stated "Yes, it lets the light in." When asked if they open them for her she stated, "Not</p>	F 248		

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

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F 248	Continued From page 26 too often." The resident was told the music the morning before was "Music with Molly." The resident stated, "Don't know that one," and "no" she did not get offered go to it.  On 1/16/14 at 5:00 pm the Administrator and the DON were informed of the findings. No additional information was provided.	F 248		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.	F 278	F278  1. On 1-16-14 Resident #9's medical record was reviewed by the MDS coordinator and the MDS coordinator submitted a modification for the admission MDS that reflects the use of a physical restraint..  2. On 1-24-14 the Director of Nursing completed an audit of the MDS of residents who have physician's orders for restraints to ensure that restraints are coded on the MDS, and no concerns were noted.  3. The MDS staff were re-educated by the Director of Nursing on 1-20-14 regarding coding on the MDS to reflect the resident's status at the time of the completion of the MDS.	2-17-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 278	Continued From page 27  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessments were accurately documented. This was true for 1 of 11 (#9) sampled residents. Inaccurate assessments can lead to potential harm when the area that was inaccurate did not trigger a potential problem for further assessment and care planning. Findings included:  Resident #9 was admitted to the facility on 7/11/13 with multiple diagnoses which included dementia and bipolar disorder.  Resident #9's 7/19/13 admission MDS assessment Section P for "Restraints" documented "Not used" for all aspects of the restraint assessment.  The Care Plan for Resident #9, dated 7/26/13, documented in part: * Problem/Need - "FALLS: I am at risk for falls r/t (related to) hx (history) of falls, poor safety awareness, altered gait and dementia;" and, * Approaches - "Sentinle {SIC} Belt to w/c [wheelchair] 7/11/13."  An admission Nurses Note for Resident #9, dated 7/11/13, documented in part, "...Pt [patient] on a low bed, concave mattress [with] mat beside bed, a sentinale {SIC} belt to W/C [wheelchair]..."  On 1/16/14 at 1:40 p.m., the MDS Coordinator was interviewed. When asked why restraints were not coded on the admission MDS, she	F 278	4. Beginning the week of 2-17-14, the Director of Nursing or designee will complete weekly audits of coding on the MDS for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that the MDS is coded to reflect the resident's status at the time of completion of the MDS. 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 this time. The Director of Nursing is responsible for monitoring and follow-up.  Date of compliance 2/17/14	2-17-14	

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

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F 278	Continued From page 28 stated, "My understanding was that he was capable of removing the belt." After looking over information on the computer, the MDS coordinator was unable to determine why restraints was not coded and stated, "It was missed then." The Regional MDS Coordinator referred the surveyor to the DON for further information.  On 1/16/14 at 2:00 p.m., the DON said Resident #9 was never able to undo the seat belt consistently. When asked why it was not coded on the admission MDS assessment, the DON stated, "I don't know why."  On 1/16/14 at 4:30 p.m., the Administrator and DON were informed of the MDS assessment inaccuracy. However, no further information or documentation was provided.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	F 280  1. On 1-15-14 Resident #6 was reassessed by Director of Nursing and no concerns were noted related to the resident being transferred with a sit to stand lift instead of the Hoyer lift. On 1/15/14 and the resident's caregiver guide, and care plan were reviewed and updated by the Director of Nursing, to reflect Resident # 6's current transfer status.	2/17/14	

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F 280	<p>Continued From page 29 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the care plans were accurate and reflected what the residents' needs were. This was true for 3 of 16 (#s 6, 8 &amp; 13) sampled residents. Inaccurate care plans could create a potential for harm if the residents needs were not met and staff failed to provide the appropriate care. Findings include:</p> <p>1. Resident #6 was admitted to the facility on 8/23/13 with diagnoses of senile dementia uncomplicated, failure to thrive, depressive disorder, and generalized muscle weakness.</p> <p>The 10/19/13 quarterly MDS assessment documented the resident: - was cognitively impaired with short and long term memory problems, - was moderately impaired decision making skills, - required extensive assistance of one to two staff for transfers, dressing, eating, personal hygiene and bathing. - was in a chair that prevents rising.</p> <p>The residents care plan, dated 9/5/13, for "Falls" documented an intervention of, "Transfers: Use Hoyer and 2 staff for transfers." On 1/13/14 at 1:35 p.m. two aides were observed to transfer the resident using a sit to stand lift. On 1/16/14 at 9:15 a.m. the DON confirmed the resident had improved with therapy and used a sit to stand lift</p>	F 280	<p>On 1-20-14 Resident #8 was reassessed by the Assistant Director of Nursing (ADON) for their current continence status and concerns were addressed as noted. On 1/20/14 the ADON nurse updated the care plan and C.N.A. caregiver guide to reflect the resident's current continence status.</p> <p>On 1/20/14 Resident # 13 was reassessed by the DON for the current use of physical restraint and concerns were addressed as noted. On 1-20-14, Resident # 13's care plan and care giver guide was reviewed and updated by the Director of Nursing to reflect the residents current restraint device.</p> <p>2. On 1-28-14, an audit of care plans was completed by the nurse managers to ensure current patient current status is reflected on the care plan, and concerns were addressed as needed.</p> <p>3. The Licensed Nursing staff were re-educated on 1-20-14, by the Director of Nursing, regarding updating care plans to reflect the resident's current status.</p>	

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F 280	<p>Continued From page 30 instead of a mechanical lift.</p> <p>2. Resident #13 was admitted to the facility on 12/27/13, with diagnoses of paralysis agitans and dementia with behavior disturbance.</p> <p>The 1/3/14 admission MDS assessment documented the resident was:</p> <ul style="list-style-type: none"> <li>- severely cognitively impaired,</li> <li>- required extensive assistance with transfers, dressing, eating, and personal hygiene,</li> <li>- was restrained in a chair that prevents rising.</li> </ul> <p>The initial care plan [Not Dated] documented a problem of, "Restraint: I am at risk for injury due to my need for a chair that prevents rising." The care plan Interventions [Not Dated] documented: "** Check lap buddy every 30 minutes and remove every two hours for re-positioning."</p> <p>The resident was observed on multiple occasions the last two days of the survey to be in his wheelchair with a lap tray in place, not a lap buddy. The dates and times of the observations were; 1/15/14 at 10:30 a.m. in the activity area, 1/15/14 at 1:30 p.m. in his room, and 1/16/14 at 9:10 a.m. and 10:55 a.m. in his room.</p> <p>On 1/16/14 at 9:15 a.m. the DON confirmed the resident used a lap tray and not a lap buddy as a restraint. No further information was provided.</p> <p>3. Resident #8 was admitted to the facility on 6/28/13 with multiple diagnoses including congestive heart failure and paralysis agitans.</p> <p>The resident's quarterly MDS assessment dated, 12/17/13, documented the resident was always</p>	F 280	<p>4. Beginning the week of 2-17-14 the nurse managers will complete weekly audits of care plans for 4 weeks and monthly for 2 months and quarterly thereafter to ensure care plans reflect the current status of the resident. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance committee will review and determine if further intervention are needed at this time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>		

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F 280	Continued From page 31 incontinent for both bowel and bladder.  The resident's ADL care plan dated 7/16/13, documented an approach, "I am usually continent of bowel and bladder and able to request assistance for toileting as needed."  On 1/16/14 at 11:23 AM, MDS Coordinator #9 was interviewed regarding the contradiction between the assessment and the care plan. She stated, "I didn't catch that on the care plan...he has declined with that skill."  On 1/16/14 at 4:30 PM, the Administrator and DON were informed of the care plan issue. No further information was provided.	F 280			
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	F309  1. On 1-20-14, Resident #9 was reassessed by the DON for concerns of not having soothing music playing in the room and no concerns were noted. On 1-28-14 the Social Services reassess resident #9 for concerns related to music not playing in the resident's room and no concerns were noted.  2. On 1-24-14, the care plans were audited by the nurse managers to ensure that items are available, and that care plans are being	2-17-14	
	This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure a resident with dementia received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This was true for 1 of 9 (#9) sampled residents when Resident #9's care plan instructed staff to play soothing music while				

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F 309	<p>Continued From page 32</p> <p>the resident rested to assist with comfort and calmness, however, it was not performed and there was no music player in the resident's room. This failed practice created the potential for increased agitation, restlessness, wandering and an increased risk for falls. Findings included:</p> <p>Resident #9 was admitted to the facility on 7/11/13 with multiple diagnoses which included dementia with behavioral disturbances and bipolar disorder.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 10/10/13, documented in part:</p> <ul style="list-style-type: none"> <li>* Unable to complete interview for cognitive patterns;</li> <li>* Trouble with sleep nearly every day;</li> <li>* Extensive assistance needed with 2 or more people for bed mobility, transfers, and toilet use;</li> <li>* Extensive assistance needed with 1 person for dressing, eating, and personal hygiene;</li> <li>* One fall since admission with no injury and one fall since admission with minor injury; and,</li> <li>* Restraints in chair/out of chair to prevent rising.</li> </ul> <p>The Care Plan for Resident #9, dated 7/26/13, documented in part:</p> <ul style="list-style-type: none"> <li>* Problem/Need - "MOOD/PSYCHOSOCIAL WELLBEING: Potential for fluctuations in mood/psychosocial wellbeing rt [related to] cognitive deficits, LTC [long term care] placement, End of Life, Family Dynamics and past decisions he has made;" and,</li> <li>* Approaches - "Play soothing music for [Resident #9] when he is in his room relaxing to assist in calming/comforting him."</li> </ul> <p>Social Services completed a Resident Social Progress Notes admission report, dated 7/12/13,</p>	F 309	<p>followed to meet the resident's needs, and no concerns were noted.</p> <p>3. The facility staff was reeducated 1-20-14; on following care plan interventions and ensuring care planned items are available.</p> <p>4. Beginning the week of 2-17-14 the Social Services Director, Activities Director or designee will complete audits weekly of the care plans for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that the care plans are followed to meet the resident's needs. 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 this time. The Administrator will be responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>	

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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)
F 309	<p>Continued From page 33 which documented in part: * "Successful interventions in the past have been music therapy especially classical music."</p> <p>A Resident Social Progress Notes quarterly report, dated 10/30/13, documented in part: * "Music has been a very important part of [Resident #9] life [and] had been a pianist, choir director and enjoyed singing hymns from church."</p> <p>On 1/13/14 at 1:30 p.m., 2:14 p.m. and 3:12 p.m., Resident #9 was observed lying on his bed. No music was heard.</p> <p>On 1/14/14 at 10:25 a.m., 2:30 p.m. and 4:00 p.m., Resident #9 was observed lying on his bed with no music playing.</p> <p>On 1/15/14 at 12:00 p.m., the surveyor observed Resident #9's room for a music playing device, however, no music player was found. At 1:43 p.m. the resident was observed lying on his bed with no music playing.</p> <p>On 1/15/14 at 3:48 p.m., CNA #1 was asked how often she was assigned to Resident #9's care. The CNA said she worked with the resident sometimes. When asked if the resident listened to music while in his room resting, the CNA stated, "[He] doesn't really listen to music as far as I know" and referred the surveyor to a CNA who worked with the resident often.</p> <p>On 1/15/14 at 3:50 p.m., CNA #2 was asked if Resident #9 listened to music while resting in his room. The CNA stated, "Now and then" and added the resident enjoyed attending the Cruisin' Classics activity. When asked if the resident had any sort of music playing device in his room, the</p>	F 309	

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

PRINTED: 01/24/2014  
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 01/17/2014
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F 309	Continued From page 34 CNA responded, "No."  On 1/16/14 at 2:15 p.m., the DON was asked why playing music for Resident #9 was placed on the Care Plan. The DON said the intervention was found during an interview with the family on admission. When asked if the intervention had been effective for Resident #9 the DON responded, "I usually see the resident in the hallway. I don't know." The DON was informed of observations with the resident resting with no music playing, and that the resident did not have a music playing device in his room. No further information or documentation was provided.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314  1. On 1-28-14 Resident #4 was reassessed by the Director of Nursing for concerns regarding skin condition and, no concerns were noted. On 1/28/14 the care plan and care giver guide was updated by the DON to reflect the resident's current status. On 1/28/14 Resident #11 was reassessed by the Director of Nursing for any concerns regarding skin condition and, no concerns were noted. On 1/28/14 the care plan and care giver guide was updated by the DON to reflect the resident's current status.	2-17-14
	This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and record review the facility failed to implement interventions to prevent pressure sores for 2 of 4 residents sampled for pressure sores, (Residents #4 and #11). The deficient practice had the potential for more than minimal harm, when Resident #11 was not provided protective boots for her feet while in bed and #4			

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F 314	<p>Continued From page 35</p> <p>had conflicting interventions on her care plan related to the amount of time she was to be up. Findings include:</p> <p>1. Resident #11 was readmitted to the facility on 7/26/13 with diagnoses that included cerebral embolism with infarct, hemiplegia, muscle weakness.</p> <p>The resident's Reentry MDS dated 8/4/13 and Quarterly dated 12/29/13, recorded: *BIMS score: 8/4/13 -12 and 12/29/13 -10 Cognition moderately intact, *Bed Mobility: Both dates - Total assist 2 persons physical assist, *Risk of Pressure Ulcers: Both dates - Yes.</p> <p>The Risk Assessment Tool dated 12/29/13, recorded: *Skin Risk Score: High</p> <p>The Braden Risk Assessment Report dated 12/7/13, recorded: *Risk Level: Mild</p> <p>Physician Orders for the month of December and January recorded: *"Floation[sic] boots on at all times in bed."</p> <p>The resident's care plan recorded: -Problem onset: 6/26/12 and Date admitted 7/26/13,</p> <p>-Skin: "I am at risk for skin breakdown r/t [related to] IDDM [Insulin Dependent Diabetes Mellitus], hemiplegia, impaired mobility."</p> <p>-Intervention: "Floation[sic] Boots on at all times when in bed."</p>	F 314	<p>2. On 1-28-14, an audit of care plans was completed by the nurse managers to ensure current patient status is reflected on the care plan and concerns were addressed as needed.</p> <p>3. The staff was re-educated on 1-20-14, by the Director of nursing, on updating and following the care plan and care giver guides to reflect the resident's current status to meet the resident's needs.</p> <p>4. Beginning the week of 2/17/14 the nurse managers will complete weekly audits of care plans for 4 weeks and monthly for 2 months and quarterly thereafter to ensure care plans are current to reflect the current status of the resident and are followed to meet the resident's needs. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Quality Assurance committee will review and determine if further intervention are needed at this time. The Director of Nursing is responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2014</b>
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F 314	<p>Continued From page 36</p> <p>The resident's CNA [Certified Nurse Aide] Daily Care Guide dated 12/29/13, recorded:</p> <p>-"Floation[sic] boots on at all times when in bed."</p> <p>The Resident Social Progress Notes dated 10/23/13, recorded:</p> <p>"She does not utilize a pillow under her head while in bed and is to wear prevalon boots at all times while in bed for skin integrity."</p> <p>On 1/13/14 at 10:50 am the resident was observed to have cares provided by CNA #4 and CNA #5, while in bed. The resident had white socks on. [NOTE: The boots were not on the resident while in bed.]</p> <p>On 1/13/14 at 2:15 pm the resident was observed to have cares provided by CNA #1 while in bed. The resident had white socks on. [NOTE: The boots were not on the resident while in bed.]</p> <p>On 1/15/14 at 9:47 am and 10:29 am the resident was observed to be in bed asleep. The resident was lying on her back with the head of her bed slightly elevated, and her feet were directly on the bed. The resident had white socks on her feet. [NOTE: The boots were not on the resident while she was in bed.]</p> <p>On 1/16/14 at 9:25 am the resident was awake in bed. The resident's feet were directly on the bed and she had white socks on her feet. [NOTE: The boots were not on the resident while she was in bed.]</p> <p>On 1/16/14 at 9:25 am the resident was awake in bed. The resident was asked if the staff ever put</p>	F 314		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	<p>Continued From page 37</p> <p>on any blue or bigger protective slippers when she is in bed. The resident stated, "No, but I have some new slippers I got for my birthday." The resident was asked if they usually put her to bed in her white socks and she stated, "Yes."</p> <p>On 1/16/14 at 9:36 am CNA #3 who was caring for the resident, was asked if there were any special cares she provided for the resident when the resident was put to bed. The CNA stated, "She uses the brace at night. The RNA [Restorative Nurse Aide] puts the brace on during the day." When asked if there were any special items for her feet when she put the resident to bed. She stated, "No, she doesn't use a pillow."</p> <p>On 1/16/14 at 9:40 am CNA #6 who was caring for the resident, was asked if there were any special needs or equipment that they provide for the resident. The CNA stated "she has a brace on her left hand." When asked about her feet, he stated "I don't know about that. I know we have to keep her in a line and no pillow."</p>	F 314		
	<p>On 1/16/14 at 9:43 am LN #7 who was caring for the resident, was asked about special needs or equipment for the resident related to her feet, she stated "they discontinued the right ankle brace on 1/10/14. She has a soft brace on her left hand. I looked at that this morning. Nothing on her feet." When asked about the boots that were an intervention on the resident's care plan and have not been provided, she stated "they didn't take that off the care plan. I'll check on that."</p> <p>On 1/16/14 at 9:46 am the ADON and LN # #8 were interviewed about the floatation boots. When the ADON was asked about the boots she stated, "I am not sure about that, ask LN #8."</p>			

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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F 314	<p>Continued From page 38</p> <p>LN#8 was asked about the boots. She stated "I did put that on there, since admission." When told they were not being provided for the resident she stated, "thanks for the heads up. I think she is on an air bed." The surveyor accompanied LN #8 into the resident's room with blue floatation boots. The resident was in bed with white socks on her feet, feet directly on the bed. LN#8 verified the resident was not on an air bed and that it was a contoured mattress. LN#8 then put the boots on the resident's feet. LN#8 asked the resident "How does that feel?" The resident stated, "Pretty good." LN#8 then stated, "Ok from now on we will have those on." CNA #6 came in and asked LN#8 about the boots. LN#8 told the CNA she had put them on and to make sure they are on and she would make sure the care giver guide had them on it.</p> <p>On 1/16/14 at 10:00 am the surveyor went back in the room with LN #8 to assess the resident's heels. Both heels were observed. The resident stated the boots "feel good, they have never been around."</p> <p>On 1/16/14 at 5:00 pm the Administrator, and the DON were informed of the findings. No additional information was provided.</p> <p>2. Resident #4 was admitted on 1/4/13 with</p>	F 314		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 314	Continued From page 39 multiple diagnoses including hypertension, retention of urine, and dementia.  The resident's Skin care plan dated 1/23/13 documented an approach, "MAY ONLY BE UP 1 H[ou]R AT A TIME."  The resident's ADL care plan dated 1/23/13 documented an approach, "...I am only to be up in my w/c [wheelchair] for 1 hour at a time."  The resident's History of Pressure Ulcer care plan dated 11/20/13 documented an undated and handwritten approach, "May be [up] in wc no longer than 2 [hours] at a time."  The resident's January 2014 Physician Orders documented an order dated 4/9/13, "MAY ONLY BE UP 1 HR AT A TIME."  On 1/16/14 at 11:30 AM MDS Coordinator #9 was interviewed regarding the care plans. She stated, "So it's a contradiction, isn't it?" When asked for clarification on which approach should be used, she indicated the one which stated '1 hour at a time' was not the current approach and, "They should have been scratched off."	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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

PRINTED: 01/24/2014  
FORM APPROVED  
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F 323	<p>Continued From page 40 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible when equipment not in use was parked in the hallways blocking handrails. This was true for 5 of 16 sampled residents, and any other residents who used the 100, 200, 300, 400 and 500 hallways for independent mobility. This failure created the potential for more than minimal harm should residents slip, trip and fall and not have access to handrails. Findings included:</p> <p>On 1/13/14 the following observations were made of equipment not in use in the 100 hallway: * 8:54 a.m., a sit-to-stand lift was parked between rooms 105 and 107 blocking the handrail; * 10:40 a.m., a Hoyer lift and sit-to-stand lift were parked between rooms 105 and 103 blocking the handrail; * 12:30 p.m., a sit-to-stand lift was parked outside of room 105 blocking the handrail, and a Hoyer lift was parked between rooms 109 and 111 blocking the handrail. LN #20 walked by the Hoyer lift, engaged the wheel brake, and continued walking down the hallway.</p> <p>On 1/13/14 the following observations were made of equipment not in use in the 200 hallway: * 10:45 a.m., a sit-to-stand lift was parked outside</p>	F 323	<p>F323</p> <p>1. On 1-29-14 the hallway for residents that reside on the 100 hall, was reassessed by the Administrator for equipment, that was not in use, being parked in the hallway and/or blocking the residents access to the handrails, no concerns were noted.</p> <p>On 1-29-14 the hallway for residents that reside on the 200 hall, was reassessed by the Administrator for equipment, that was not in use, being parked in the hallway and/or blocking the residents access to the handrails, no concerns were noted.</p> <p>On 1-29-14 the hallway for residents that reside on the 300 hall, was reassessed by the Administrator for equipment, that was not in use, being parked in the hallway and/or blocking the residents access to the handrails, no concerns were noted.</p> <p>On 1-29-14 the hallway for residents that reside on the 400 hall, was reassessed by the Administrator for equipment, that was not in use, being parked in the hallway and/or blocking the residents access to the handrails, no concerns were noted.</p> <p>On 1-29-14 the hallway for residents that reside on the 500 hall, was reassessed by the Administrator for equipment, that was not in use, being parked in the hallway</p>	2-17-14	

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

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F 323	<p>Continued From page 41</p> <p>of room 213 blocking the handrail for 30 minutes; * 12:21 p.m., a sit-to-stand lift was parked between rooms 213 and 215 blocking the handrail, and a Hoyer lift was parked outside of room 211 blocking the handrail until 12:40 p.m.; * 2:30 p.m., a sit-to-stand lift was parked outside of room 203 blocking the handrail. It was still there 40 minutes later; * 2:40 p.m., a staff member was observed leaving room 203 with a Hoyer lift. The lift was parked behind a sit-to-stand lift which blocked the handrail for 40 minutes.</p> <p>On 1/13/14 at 8:47 a.m., a sit-to-stand lift was parked outside of the Royal Fork dining room blocking handrails in the 300 hallway.</p> <p>On 1/13/14 at 2:30 p.m., a Hoyer lift was parked outside of room 407 which blocked the handrail. Another Hoyer was parked outside of room 403 which also blocked the handrail for 40 minutes.</p> <p>On 1/13/14 the following observations were made of equipment not in use in the 500 hallway: * 8:17 a.m., a Hoyer lift was parked between room 507 and a soiled linen closet which blocked the handrail for 30 minutes. It was observed in the same location again at 9:10 a.m.; * 8:47 a.m., a sit-to-stand lift was parked by room 509 blocking the handrail for 23 minutes. It was observed in the same location at again at 10:54 a.m. * 10:54 a.m., a staff member exited from room 526 with a Hoyer lift and parked it outside of the room, blocking the handrail, directly across from a sit-to-stand lift which was also blocking the handrails. Both sides of the hallway were blocked by lift equipment; * 2:30 p.m., a sit-to-stand lift was parked outside</p>	F 323	<p>and/or blocking the residents access to the handrails, no concerns were noted. <i>2-17-14</i></p> <p>2. On 1-20-14 the hallways in the facility were re-assessed by the Maintenance Director and the Administrator to ensure that residents had access to the handrails in common areas and concerns were addressed if needed.</p> <p>3. On 1-20-14, the facility staff was reeducated by the Maintenance Director, and the Administrator on keeping hallways clear of equipment and keeping necessary items on the same side of the hallway and to store when not being utilized to not impede egress and promote safety.</p> <p>4. Beginning the week of 2-17-14 the Maintenance Director or designee will complete 3 audits of the hallways that they are clear of lifts or other equipment and timely moving of equipment so as not to impede egress, weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that residents have access to handrails in the hallways. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Maintenance Director is responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>	

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

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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD</b> <b>NAMPA, ID 83686</b>		
(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 323	<p>Continued From page 42</p> <p>of room 509 which blocked the handrail. It was then observed to be moved to the opposite side of the hallway, still blocking the handrail. The lift equipment was in the same location 45 minutes later.</p> <p>Similar observations were made on 1/14/14, 1/15/14 and 1/16/14.</p> <p>On 1/16/14 at 11:02 a.m., CNA #13 was asked where lift equipment was stored when not in use. She said they usually put it in the storage room with slings and other equipment.</p> <p>On 1/16/14 at 11:04 a.m., Unit Manager #15 was asked where lift equipment was stored when not in use at which she replied, "Everything is supposed to be on one side [of the hallway]."</p> <p>On 1/16/14 at 11:05 a.m., CNA #14 was asked where lift equipment not in use was stored. She said during the day they keep the equipment close, otherwise it would be stored in the storage room.</p> <p>On 1/16/14 at 4:30 p.m., the Administrator and DON were informed of the equipment storage issue. However, no further information or documentation was provided.</p> <p>2. On 1/13/14 at 11:10 am on the 100 Hall, a Hoyer lift and a Sit to Stand lift were observed to be parked between the doors to rooms 103 and 105. The equipment was blocking the use of the hand rails. The equipment made it difficult to have more than one line of traffic move down the hall. There was a single line, five residents were in wheelchairs causing congestion in the hallway along the blocked area. The residents were</p>	F 323			

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

PRINTED: 01/24/2014  
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 01/17/2014
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 323	<p>Continued From page 43</p> <p>propelling in the direction towards the Physical Therapy room at the end of the hall. At 11:15 am a CNA took the Hoyer and joined in the traffic moving down the hall. At 11:16 am a CNA took the Sit to Stand into a room and the traffic congestion cleared.</p> <p>On 1/13/14 at 12:24 pm the Hoyer lift was parked between rooms 109 and 111. The Sit to Stand was parked between rooms 103 and 105. Both pieces of equipment were blocking the use of the hand rails.</p> <p>On 1/13/14 at 1:47 pm, the Hoyer lift was parked between rooms 109 and 111. The Sit to Stand was parked between room 101 and the Nourishment room. Both pieces of equipment were blocking use of the hand rail.</p> <p>On 1/13/14 at 1:55 pm the Hoyer lift remained between rooms 109 and 111. The LN's medication cart was parked on the opposite side of the hall between rooms 112 and 114. With both of these items across from each other the hallway was narrowed. A resident was being wheeled down the hall and the volunteer who was pushing the wheelchair had to maneuver around the equipment to get past.</p> <p>On 1/13/14 at 2:40 pm the Hoyer lift was parked between rooms 109 and 111. The Sit to Stand was parked between rooms 105 and 107. The equipment was blocking the use of the hand rails.</p> <p>On 1/13/14 at 3:08 pm the Sit to Stand was parked between rooms 105 and 107, blocking the use of the hand rail.</p> <p>On 1/13/14 at 3:17 pm, an activity had completed,</p>	F 323		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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F 323	<p>Continued From page 44</p> <p>and 4 resident were observed propelling themselves and being pushed down the 100 Hall towards the Physical Therapy room. The Sit to Stand was parked between rooms 105 and 107. One resident that was propelling herself stopped across from the Sit to Stand causing congestion in the area, because of the narrow hallway. Only one wheelchair was able to pass through the area at a time.</p> <p>On 1/14/14 at 10:22 am the Hoyer lift was parked between rooms 109 and 111. Between rooms 109 and the fire door the housekeeping cart and a vacuum was parked. The equipment blocked the use of two sets of handrails.</p> <p>On 1/14/14 at 10:31 am the Hoyer lift, housekeeping cart and vacuum remained in the same spot. The Sit to Stand was also parked outside rooms 103 and 105. The equipment blocked the use of three hand rails on the odd numbered side of the hall.</p> <p>On 1/14/14 at 12:35 pm the Dietary room tray cart was parked between rooms 109 and 111. The Hoyer lift was parked between Room 109 and the fire door. The Sit to Stand was parked between rooms 103 and 105. The equipment was blocking the use of three of the handrails. A resident was observed propelling herself down the even numbered side of the hall in the direction of the Physical Therapy room. When she reached the end of the hall she was observed to turn around and propel herself up the odd numbered rooms side of the hall. While traveling up the odd numbered side of the hall she was unable to follow the hand rail, and maneuvered herself around the equipment and then back to the rail each time she came to the equipment.</p>	F 323		

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 01/17/2014	
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 323	Continued From page 45  On 1/16/14 at 3:50 pm LN#19 who was caring for residents on the 100 Hall, was asked if the Hoyer lift and the Sit to Stand equipment was kept in the hall, she stated "pretty much cuz they are always using them."  On 1/16/14 at 5:00 pm the Administrator and the DON were informed of the findings. No additional information was provided.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329  1. On 1-28-14 Resident #9 was reassessed by the Director of Nursing for the need of antianxiety medication and clarified the diagnosis for the medication with the Physician to include current target behaviors, and concerns were addressed as needed.  On 2-3-14 the attending physician for Resident #10 provided communication and information related to the continued clinical need of the antipsychotic. On 1-28-14, Resident # 10 was reassessed by the Director of Nursing for behaviors and interventions and for the need of continued	2-17-14
			use of the antipsychotic and concerns was addressed as needed	

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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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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F 329	<p>Continued From page 46</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure unnecessary medications were not administered to a resident without clinical indications for use. This was true for 3 of 11 (#4, 9 and 11) sampled residents. This practice created the potential for harm should the medication regimen result in or contribute to an unanticipated decline or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #9 was admitted to the facility on 7/11/13 with multiple diagnoses which included dementia with behavioral disturbances, bipolar disorder and epilepsy.</p> <p>Resident #9's most recent quarterly MDS assessment, dated 10/10/13, documented in part: * Unable to complete interview for cognitive patterns; * Moderately impaired with daily decision making, cues/supervision required; * Inattention, disorganized thinking and psychomotor retardation that comes and goes and changes in severity; * Trouble with sleep nearly every day; and, * Behavior not exhibited for physical behavior symptoms directed toward others, verbal behavioral symptoms directed toward others, rejection of care and wandering.</p> <p>The Care Plan for Resident #9, dated 7/24/13, documented in part: * Problem/Need - "MOOD/PSYCHOSOCIAL WELLBEING: Potential for fluctuations in mood/psychosocial wellbeing rt [related to]</p>	F 329	<p>On 1-28-14 resident #4 was reassessed by the Director of Nursing for continued need of antipsychotic and the Physician documented the diagnosis related to prescribe psychoactive medication for the target behaviors for the use of medication and concerns were addressed as needed.</p> <p>2. On 1-27-14 an audit of Patients receiving psychoactive medications was completed by the nurse managers to ensure that medication is being given for a required diagnosis, clinical symptoms and that target behaviors match the indications for the prescribed medication and concerns were addressed as needed.</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD</b> <b>NAMPA, ID 83686</b>	
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F 329	Continued From page 47 cognitive deficits, LTC [long term care] placement, End of Life, Family Dynamics and past decisions he has made;" * Approaches - "SS [Social Services] to visit PRN [as needed] to assess mood and effectiveness of psychotropic medication. Notify NSG [Nursing]/SS of any decreases in mood and document on behavior monitor;" * Problem/Need - "PSYCHOTROPIC USE: I am at risk for side effects from antipsychotic drug use;" * Approaches - "Administer my medication as ordered by physician; Observe me for adverse side effects, document and report to my physician; Monitor my behavior... Monitor me for signs of tremor and document. Report onset or increase to my physician;" * Problem/Need - "ANTIDEPRESSANT: I am at risk for side effects from antidepressant medication use;" * Approaches - "Administer my medication as ordered by physician... Monitor me for signs of extrapyramidal symptoms and document; Observe me for adverse side effects which may include: fatigue, sedation, dizziness, weakness, rash, anxiety; If noted, document and report to physician; Monitor and record my target behaviors (insomnia);" * Problem/Need - " BEHAVIOR: My wandering intrudes on other residents' privacy;" * Approaches - " Place me in area where frequent observation is possible; Alert staff to my wandering behavior; Provide diversional activities for me; Redirect me when I wander into other resident's rooms; Approach me positively and in calm, accepting manner; If I wander away from unit, instruct staff to stay with me, converse and gently persuade me to walk back to designated area with them; Monitor and document my	F 329	3. Licensed nursing staff was re-educated on 1/20/14, by the Director of Nursing on ensuring that the antipsychotic medications have a clinical need, diagnosis, that documented behaviors match the target behaviors listed for that medication, that behaviors are documented as needed, and for the administration of the prescribed indication of the medication is being followed. On 1-27-14 Medical Records and Nursing staff was re-educated by the Director of Nursing on requirements for Pre-Admission Screening and Resident Review (PASRR) and requirements to attempt dosage reduction on new admissions that do not trigger a PASRR level II screens, within 2 weeks if there is not a clinical indication with physician's evaluation for continued use of an antipsychotic.  4. Beginning the week of 2-17-14 the Nurse Managers, Medical Records or designee will complete weekly audits of residents who require the use of psychoactive medications weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure that diagnosis for psychoactive medications and target behaviors are clearly documented and that the physician has evaluated new residents admitted on	

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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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F 329	<p>Continued From page 48</p> <p>behavior... Staff assigned to this resident's room should account for my whereabouts throughout the day."</p> <p>a. Clinical Chart reports from Resident #9's Hospice agency documented in part: * 8/13/13 Orders - "Start Depakote at 250 mg [milligrams] capsules po [by mouth] BID [two times per day] (Note goal for him may be around 1000 mg a day. Will need to do blood tests after we exceed 500 mg) 2 weeks;" * 9/6/13 Body Systems Neurology Finding: Comments - "Started on Depakote for wandering. No side effects noted;" * 9/6/13 Body Systems Self Esteem Mental Status Finding: Comments - "Depakote is being adjusted for wakefulness at night;" and, * 9/6/13 Coordination of Care: Discussion - "Continue with Depakote titration for sleep."</p> <p>Note: The order on 8/13/13 did not provide an indication for use of Depakote. The comments and coordination of care on the 9/6/13 hospice visit documented the indication of use was for wandering, wakefulness at night and sleep, making it unclear which behavior was the target behavior for use of the medication.</p> <p>Telephone Orders for Resident #9 documented in part: * 8/14/13 - "Depakote 250 mg PO BID. (Note goal may be around 1000 mg a day, will need to do blood test after 500 mg is exceeded) 2 wks [weeks];" Note: No indication of use was documented on the telephone order. * 9/4/13 - " [Increase] Depakote to 750 mg PO TID [three times per day] Dx [diagnosis] seizures;"</p>	F 329	<p>antipsychotics without a level II screen as required for continued need of an antipsychotic. 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. The Director of Nursing will be responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 49</p> <p>* 9/9/13 - " [Decrease] Depakote to 500 [mg] TID D/C [discontinue] VPA [valproic acid] level ordered on 8-29. VPA level 2 wks from Today [with] scheduled labs Dx Seizures;"</p> <p>* 9/11/13 - "1. Depakote 500 mg po bid Dx: behaviors/dementia not for seizures so will titrate for behaviors not levels; 2. Depakote level in 2 weeks;" and,</p> <p>* 9/12/13 - "Hold Trazodone until pt [patient] more awake, Then restart. D/C Depakote."</p> <p>Note: The orders on 9/4/13 and 9/9/13 documented the diagnosis of seizures for the indication for use of Depakote. The intended indication, dated 9/11/13, documented the medication was for behaviors related to dementia. However, a specific target behavior was not identified.</p> <p>Resident #9's August and September 2013 MAR (Medication Administration Record) documented Depakote was administered per Physician Orders.</p> <p>A Subsequent Nursing Facility Chart Note for Resident #9, dated 9/9/13, documented in part:</p> <p>* History of Present Illness: Altered Mental Status - "The symptoms began on 09/09/2013. The symptoms are reported as being moderate. The symptoms occur constantly. He states the symptoms are of new onset. I recently increased his depakote for a low VPA level and he is clearly oversedated from it so will reduce his dosing and check VPA level in 2 weeks;"</p> <p>* Physical Exam: General Exam - "over[se]dated from depakote. Does arouse to commands. Level of consciousness - lethargic;"</p> <p>* Assessment/Plan: Description - "Oversedated from last increase in his Depakote for a low VPA</p>	F 329			

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 50 level so will return him to 500 mg tid and check VPA level in 2 weeks."</p> <p>A Subsequent Nursing Facility Chart Note for Resident #9, dated 9/13/13, documented in part: * History of Present Illness: 1. Altered Mental Status - "He states the symptoms have improved. [Resident #9] is finally more awake with the d/c of depakote; 2. Follow Up of dementia with behaviors - "He states the symptoms are stable. He clearly is very sensitive to Depakote so will stop it altogether. Will not restart unless behaviors are reported and if so will start at a very low dose."</p> <p>b. Resident #9's January 2014 recapitulation Physician Orders documented in part: * 7/14/13 - "Lorazepam 2 MG/ML [milliliters] Take By Mouth 0.25 ML every 2 Hrs [hours] PRN Dyspnea."</p> <p>A Psychopharmacological Evaluation form for Resident #9, dated 7/14/13, documented in part: * Diagnosis - "dyspnea;" * Behaviors - "1. S/S [signs and symptoms] of anxiety - dyspnea; 2. SOB [shortness of breath];" * Describe non-pharmacological interventions used to minimize the behaviors - "assess for pain/discomfort;" and, * Psychoactive Medications: Current Dose - "Ativan 2 mg/ml 0.25 ml po/sl [sublingual] q [every] 2 [hours] prn."</p> <p>A December 2013 PRN Administration Record for Resident #9 documented Lorazepam was administered as follows: * 12/14/13 at 12:00 a.m. for "[Increased] restless[ness] (not staying in bed), Req[uested] by aide." Results were marked as positive;</p>	F 329		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 51</p> <p>* 12/20/13 at 3:00 p.m. for "[Increased] rocking, restless." Results were marked as negative 1 hour later;</p> <p>* 12/20/13 at 5:00 p.m. for "Rocking, Agitated." Results were marked as positive 2 hours later;</p> <p>* 12/21/13 at 7:30 p.m. for "bouncing legs, Agitated." Results were marked as negative 1 hour later;</p> <p>* 12/21/13 at 9:30 p.m. for "Rocking, climbing out of bed." Results were marked as negative 30 minutes later;</p> <p>* 12/22/13 at 5:00 p.m. for "Rocking, leg movement." Results were marked as positive 1 hour later.</p> <p>Nurses Notes for Resident #9 documented in part:</p> <p>* 12/21/13 at 9:00 p.m., "Res[ident] having [increased] agitation. Self transferred from bed to wc [wheelchair]. Couldn't keep legs still, kept saying out loud "I'm going to die." When asked if he was in pain, Res[ident] responded yes. When asked if his legs hurt Res[ident] responded yes. Ativan given at 1600 [4:00 p.m.] [and] 1800 [6:00 p.m.] along [with] HS [bedtime] meds [medications]. Res[ident] is resting comfortably,"</p> <p>* 12/21/13 at 9:30 p.m., "Res[ident] has [increased] agitation during PM shift. Legs become irritable and Res[ident] has difficult time sitting still. [First] dose of Ativan given at 1930 [7:30 p.m.]. Minimal relief. Res[ident] continued to climb out of bed multiple times [after] [fourth] attempt Res[ident] brought out to nurses station. Res[ident] rocked [and] put legs over wc multiple times. At 2130 [9:39 p.m.] [second] dose of Ativan given. Res[ident] continues to rock [and] tap feet on floor."</p> <p>Note: The medication was administered for</p>	F 329		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 52</p> <p>reasons other than the prescribed indication of use.</p> <p>On 1/15/14 at 2:25 p.m., the DON was asked why Resident #9 was started on Depakote, at which she said possibly for intrusive wandering and added hospice ordered the medication. The DON was informed of the issue with Lorazepam being administered for reasons other than the prescribed indication for use at which she stated, "Looks like we need to clarify." No further information or documentation was provided which resolved the issue.</p> <p>2. Resident #10 was admitted to the facility on 11/27/13 with diagnoses that included depression, and dementia.</p> <p>The resident's MD Nursing home visit dated 12/3/13, recorded: -Past Medical History: "depression, anxiety, GERD [gastroesophageal reflux disease], dementia with some history of sundowning"</p> <p>The admit MDS assessment dated 12/4/13, recorded: *BIMS score: 13- Cognitively Intact *Active Diagnoses: Non-Alzheimer's dementia, Anxiety disorder, Depression(other than bipolar).</p> <p>The resident's Admission Orders dated 11/27/13, recorded: -Risperdal 0.5 mg [1] tab[tablet] po[by mouth] qHS[every hour of sleep] anxiety. -Lorazepam 0.5 mg po [1] tab BID [ two times a day] prn[as needed] anxiety.</p> <p>The resident's Physician Orders dated January 2014, recorded: -Risperidone 0.5 mg Take by mouth once daily at</p>	F 329			

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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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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F 329	<p>Continued From page 53</p> <p>HS Dementing Illness with associated Behavioral symptoms.</p> <p>-Ativan 0.5 mg Take by mouth twice daily pm anxiety.</p> <p>The resident's "Psychopharmacological approval by Resident or Surrogate" signed and dated on 11/17/13 by the resident's son and signed and dated by the resident's MD on 12/3/13, recorded:</p> <p>-I give my consent for the medication "Risperdal" to be given in dosages not to exceed those recommended in the physician's desk reference, product insert, or pharmacy guidelines.</p> <p>-It was recommended for: "dementia [with] assoc. [associated] behaviors." [NOTE: No behaviors were listed.]</p> <p>-The Interdisciplinary team agrees with the above plan of care. Signed: [One Licensed Nurse signature]. [NOTE: There were five other signature lines on the form all were blank.]</p> <p>The resident's Care Plan dated 11/27/13, recorded:</p>	F 329		
	<p>*Problem: I am at risk for side effects from antipsychotic drug use. Risk vs benefit including risk of death.</p> <p>*Approaches:</p> <p>-Review in Psychotropic Committee per facility protocol.</p> <p>-Administer my medication as ordered by physician.</p> <p>-Monitor and document my behaviors on behavior monitor.</p> <p>-Pharmacy consultant review of my medication monthly.</p> <p>[NOTE: A care plan for the use of risperidone,</p>			

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

PRINTED: 01/24/2014  
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 01/17/2014
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 329	<p>Continued From page 54 and specific clinical indications and behaviors to monitor was not provided to the surveyor.]</p> <p>The resident's Medication Administration Record for the month of November 2013, recorded the Risperidone 0.5 mg Take by mouth once daily at HS was administered 11/27 thru 11/30. [NOTE: This was from the day of admission.]</p> <p>The resident's Medication Administration Record for the month of December 2013 recorded the Risperidone 0.5 mg had been administered daily throughout the month.</p> <p>The facility used two forms for tracking behaviors, one was for "Verbal abuse towards staff," and the other was for "Agitation."</p> <p>The resident's Psycho-Pharmacological Record dated 12/7- 12/31, 2013, recorded all zeros for :</p> <p>*Behavior: Verbal Abuse towards staff -Precipitating Factors:- Dementia/Confusion, Pain, Dx[diagnosis] of anxiety. -Start Date: 12/6/13 [NOTE: There was no recorded verbal abuse towards staff documented in the monitored time frame, 12/7-12/31.]</p> <p>*Interventions: 1.) Check for pain, 2.) Set limits/boundaries, 3.) Ask Pt. what she feels anxiety about, 4.) She enjoys watching TV, the news, and likes country music, 5.) Meds as ordered.</p> <p>The resident's Psycho-Pharmacological Record dated 12/8-12/31, 2013, recorded all zeros except for 2 episodes of behaviors on 12/8, for:</p> <p>*Antipsychotic monitoring:</p>	F 329		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	<p>Continued From page 55</p> <p>*Behavior: Agitation [NOTE: There were no recorded behaviors to monitor for revealing the resident was agitated.] -Precipitating Factors: -Dementing illness with assoc[associated] behaviors, Pain/discomfort/Rheumatoid Arthritis, Hx of agitation -Start Date: 12/6/13 [NOTE: The start date was two days prior to 12/8/13, when the recording on the monitor actually began.]</p> <p>*Interventions: 1.) Check for pain/discomfort/other care needs, 2.) [Resident's name] likes to be as independent as she can be, 3.) Medication as ordered.</p> <p>*Outcome: +[positive], -[negative]</p> <p>On 12/8/13 the night shift LN recorded a zero, then recorded over that with a nonlegible number, with interventions 1-3 and a positive outcome. The evening shift LN recorded a x 3 with interventions of 1-3 and a positive outcome.</p> <p>The resident's Psycho-Pharmacological Record for 1/1- 1/16, 2014 recorded:</p>	F 329		
	<p>*Behavior: Verbal Abuse towards staff -Precipitating Factors:- Dementia/Confusion, Pain, Dx[diagnosis] of anxiety. -Start Date: 12/6/13</p> <p>*Interventions: 1.) Check for pain, 2.) Set limits/boundaries, 3.) ask Pt. what she feels anxiety about, 4.) She enjoys watching TV, the news, and likes country music, 5.) Meds as ordered.</p>			

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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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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F 329	<p>Continued From page 56</p> <p>*Outcomes: +, -</p> <p>On 1/6/14 the night shift LN recorded x 1 for behavior and 1-3 for interventions, with positive results. On 1/8/14 the night shift LN recorded 1 for behaviors and 1-3 for interventions, with no outcome recorded.</p> <p>The resident's Psych-Pharmacological Record for 1/1/14- 1/16/14 recorded all zeros except for 4 episodes, for:</p> <p>*Antipsychotic monitoring:</p> <p>*Behavior: Agitation</p> <p>-Precipitating Factors:</p> <p>-Dementing illness with assoc[associated] behaviors, Pain/discomfort/Rheumatoid Arthritis, Hx of agitation</p> <p>-Start Date: 12/6/13</p> <p>*Interventions: 1.) Check for pain/discomfort/other care needs, 2.) [Resident's name] likes to be as independent as she can be, 3.) Medication as ordered.</p>	F 329		
	<p>*Outcome: +, -</p> <p>On 1/6/14 the night shift LN recorded x 2 behaviors, with no interventions and positive outcomes. On 1/6/14 the day shift LN recorded x 1 behaviors with 1-3 interventions with positive outcomes. On 1/7/14 the night shift LN recorded x 2 behaviors with no interventions and a negative outcome. On 1/8/14 the night shift LN record x 1 behavior with no interventions and negative outcome.</p> <p>The resident's Resident Social Progress Notes</p>			

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

PRINTED: 01/24/2014  
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F 329	<p>Continued From page 57 dated 12/2/13, - Admit note recorded:</p> <p>"The Pt. [patient] is alert with confusion and able to make needs known." "She denies any anxiety or depression and states she is comfortable in room." "She takes risperidone for dementing illness with associated behavioral symptoms, and ativan for anxiety, zoloft for depression and medication for pain control. Pt. denied pain during visit today and mood has been stable during visits since admit." "Nursing also states that Pt. has been verbally aggressive with increased agitation. Pt has been calling out at times as well."</p> <p>On 1/16/14 at 12:50 pm the Team Leader spoke with the ADON, Administrator and Medical Record staff, related to Resident #10's Level 2 PASARR. They were informed the resident's PASARR was not a level 2. They were informed of the changes in F329 related to the 2 weeks after admission and the need for the facility to evaluate residents need for psychotropic medications. They were advised of the Informational letter change with F309 and F329. The resident did not have a medical diagnosis for medication use. They were advised of the need for sign and symptoms and not diagnosis information.</p> <p>On 1/16/14 at 12:20 pm the ADON was asked for the documentation on the resident that reveals indications for use and the specific behaviors the staff were monitoring related to the use of the risperidone. At 12:40 pm the ADON provided the resident's chart and stated "she came in with it for depression, anxiety and sundowning." The surveyor explained to the ADON that she was looking for the Clinical Indications, and what are the sign and symptoms [resident's name] has for</p>	F 329		

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 329	Continued From page 58 the use of risperidone. The ADON stated "Oh, I will look for it." The ADON stated the resident did not wander but had verbal abusive behaviors towards staff. She was asked for documentation of the behaviors.  On 1/16/14 at 2:15 pm the ADON provided documentation that the MD wrote the risperidone order and it was for depression and anxiety. It was explained to her these are diagnoses and the surveyor was looking for clinical indications. The surveyor explained that the Regulations under F329 require if a resident comes in with an antipsychotic medication ordered without clinical indications for use that meet the Guidance, that the facility tries a GDR [Gradual Dose Reduction] within 2 weeks of admit. the ADON stated "Obviously we don't have it."	F 329		
	3. Resident #4 was admitted to the facility on 1/4/13 with multiple diagnoses including			

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

PRINTED: 01/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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F 329	<p>Continued From page 59 dementia, malaise and fatigue.</p> <p>The resident's 11/7/13 quarterly MDS assessment documented the resident: -did not exhibit delusional behaviors; and, -did not have any physical, verbal or other behavior symptoms directed toward others.</p> <p>The Physician Orders for January 2014 documented on 1/9/13 the resident was on Risperdal 0.5 mg (.25 mg twice daily) for, "Dementia with Agitated Features." Note: The diagnosis and indications for use for the Risperdal was inadequate as outlined by F329 interpretive guidance.</p> <p>The resident's Behavior care plan dated 1/23/13, documented an approach to, "Monitor and document my behavior."</p> <p>The resident's January 2014 Psycho-Pharmacological Record documented a start date of 7/29/13 for monitoring, "Agitation, hx [history] of picking behaviors, Dementia/Delerium [sic], Pain/discomfort." The Record documented the resident did not exhibit any behaviors for the month of January 2014.</p> <p>The resident's Psychotropic and Psychopharmacological Review &amp; Summary dated 10/8/13 and signed by the resident's physician on 10/16/13, documented the resident did not exhibit behaviors in August and October 2013 and only 3 behavioral events occurred in September 2013. The record also documented the resident's dose should be maintained.</p> <p>The resident's Physician notes documented the following:</p>	F 329		

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

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FORM APPROVED  
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F 329	<p>Continued From page 60</p> <p>"-1/9/13, The patient has had significant delirium and confusion following his hospital stay...He has been somewhat delusional with pulling out his Foley [catheter], taking staples out of his lower incision and pulling out an IV well [sic] in the hospital. He has required a sitter. He becomes quite combative and aggressive.</p> <p>-1/30/13, The patient is now on Risperdal 0.5 mg...for his delirium due to his dementia and he seems to be doing better with that.</p> <p>-3/27/13, The patient had quite a bit of delirium when he came in, his mental status is better now...he is not nearly as anxious and delusional.</p> <p>-6/19/13, The patient is on Risperdal 0.25 mg p.o. b.i.d. [by mouth twice a day] due to his psychosis from his dementia. This has been helpful for him and needs to be continued.</p> <p>-8/7/13, The patient remains on a very low-dose Risperdal...This seems to help with some of his delirium and confusion. He is usually compliant with cares;</p> <p>-12/4/13, The patient does have a history of acute delirium. When he first came in, he had been on Risperdal 0.5 mg p.o. b.i.d. That has worked well for him. It allowed him to participate in cares a little better, not to be as fidgety, getting in and out of bed and with falls. I am going to continue him on that for now but may want to consider whether he could come off of that, but I am afraid that a reduction at this time would cause an increase in his psychosis and significant risk to him, so we will continue with this for now."</p> <p>Note: The resident's Psychotropic and Psychopharmacological Review &amp; Summary and Physician notes after 1/9/13 indicated the resident did not exhibit harmful behaviors to self or others.</p> <p>On 1/16/14 at 10:15 AM, the DNS was interviewed regarding why the resident was still</p>	F 329		

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

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FORM APPROVED  
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F 329	<p>Continued From page 61</p> <p>on the Risperdal and she stated, "It's his agitation." She also said the doctor decided what the proper diagnosis should be, not the facility. When asked if the resident had exhibited any harmful picking behaviors, she stated, "Not that we see." She also said the resident wore long sleeves to prevent the resident from picking at his skin. She said she would try to find more information regarding the medical justification for the use of the Risperdal.</p> <p>On 1/16/14 at 1:40 PM, the DNS told the surveyor she could not find any other reason the physician prescribed the anti-psychotic medication for the resident.</p> <p>On 1/16/14 at 3:55 PM, the DNS brought physician notes (see above) dated 1/9/13 to the surveyor which indicated the resident had initially pulled out his catheter and was a harm to himself. When asked if the catheter pulling had been a behavior the facility had monitored, she said it was not. When asked what the facility had been monitoring, she said the agitation.</p>	F 329		
F 365 SS=D	<p>On 1/16/14 at 4:30 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.</p> <p>483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 365	<p>F 365</p> <p>1. On 1-24-14 resident #10 was reassessed by the Dietary Manager for food preference, changes or concerns and none were noted. On 1-24-14 resident #10 was reassessed by the DON for concerns of her meal choices and no concerns were noted.</p>	2-17-14

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

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F 365	<p>Continued From page 62</p> <p>Based on observation, resident interview, staff interview and record review it was determined the facility failed to ensure 1 of 16 sampled residents (Resident #10) was provided food prepared in a form that met the individual need of the resident. The deficient practice had the potential to cause more than minimal harm when the resident was served food items that would cause the resident gastric distress, and was served items that were not the resident's preference. Findings include:</p> <p>Resident #10 was admitted to the facility on 11/27/13 with diagnoses that included GERD [Gastroesophageal Reflux Disease].</p> <p>The resident's Admission Orders, dated 11/27/13, recorded: *Omeprazole 20 mg[milligrams] coated capsule po[by mouth] QD [every day].</p> <p>The resident's Admit MDS dated 12/4/13, recorded: *BIMS score: 13- Cognitively Intact.</p> <p>The resident's Care Plan dated 11/27/13, recorded:</p> <p>*Problem: Nutrition: At risk for weight loss due to possible low meal intakes R/T [related to] mechanically altered diet.</p> <p>*Approaches: -We will honor all likes and dislikes within reason.</p> <p>*Problem: I am at risk for gastric upset secondary to GERD and nausea. -Encourage me to sit upright during meals. Avoid lying down immediately following meals.</p>	F 365	<ol style="list-style-type: none"> <li>2. On 1-27-14 the Dietary Manager audited and reviewed dietary preference cards with the residents and preference cards were updated as needed.</li> <li>3. On 1-20-14 nursing staff were re-educated on ensuring that diet card preferences are served and conflicting menu choices are clarified prior to being served their meal. On 1-27-14 Dietary staff were re-educated on ensuring that diet card preferences are served and conflicting menu choices are clarified prior to being served their meal.</li> <li>4. Beginning the week of 2-17-14, the Dietary Manager or designee will complete 3 audits weekly of the dining room service weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure items served match dietary preference cards and meal choices, and conflicting menu orders are</li> </ol>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 365	<p>Continued From page 63</p> <p>*Approaches: -Observe me for tolerance of diet. -Observe me for s/s[sign and symptoms] of gastric upset(i.e., N/V, heartburn, gastric pain [sic], etc.).</p> <p>The resident's Meal Tray Card dated 1/13/14 lunch, recorded: *No Fish, Tomato or Citrus</p> <p>The resident's Week at a Glance Menu for the week of January 12th-18th recorded the resident's circled choices for lunch on 1/13/13, as:</p> <p>-Cheese Enchilladas [sic] or Salisbury Steak, Mashed Potatoes/Gravy, Corn.</p> <p>-Items crossed out were Spanish Rice, Lettuce and Tomato and Mandarin Oranges.</p> <p>On 1/13/14 at 12:34 pm the resident was sitting in the dining room eating her lunch. She had a plate of food with Enchiladas with red sauce, Spanish rice, a bowl of stewed tomatoes, and a bowl of mandarin oranges in front of her. When asked how her meal was she showed the surveyor the tray card that had recorded no fish, tomato or citrus. The resident stated "I'm not eating because I have acid reflux." Resident propelled herself in her wheelchair from the table. At the door exiting the dining room Employee #12 assisted the resident through the door, and stated to the resident, "You didn't eat much of your meal." The resident propelled herself out of the dining room down the hall. [NOTE: Employee#12 did not offer the resident a substitution for the meal, even though the resident had not eaten her meal.]</p>	F 365	<p>clarified prior to being served their meal. 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. The Dietary Manager and the Director of nursing are responsible for monitoring and follow-up.</p> <p>Date of compliance 2/17/14</p>	

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

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F 365	Continued From page 64  On 1/13/14 at 1:30 pm the resident was interviewed while sitting in her room in her wheelchair. When the resident was asked about the food in the facility, she stated "the food is good, it's great." "Today they gave me food that's not on the chart." When asked if that happens very often she stated "Only a week ago, I don't know what I ate, but I had built up acid. I told this girl and she told me nothing was wrong with me. I blew up, yeh I was throwing up." When asked if that happens often, the resident stated "It was the first time."  On 1/16/14 at 2:19 pm the CDM was interviewed. When she was told about the food given to the resident on 1/13/14 she stated, "that was someone who did not read her card correctly. Someone should have offered her something else." The Week at a Glance menu was shown to the surveyor. The CDM stated the family helps the resident fill it out. When asked about both the main meals being circled as a choice and what the staff should have done, she stated "Yes the Salisbury steak would have been a better choice when they saw the card." When asked what she would have done, she stated "would probably have a CNA clarify with the resident." When the CDM was asked where the no fish, tomato or citrus had come from, she stated "It's personal preference from a conversation with her within the first week of being in the facility."	F 365			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  On 1/16/14 at 5:00 pm the Administrator and the DON were informed of the findings. No additional information was provided.	F 441			

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

PRINTED: 01/24/2014  
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 01/17/2014
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 441	<p>Continued From page 65</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F 441</p> <p>1. On 1-24-14 resident #11 was reassessed by the Director of Nursing for care concerns related to infection control practices and none were noted. On 1/27/14 infection control practices for residents residing on 200 halls was completed by the nurse managers and concerns were addressed as noted.</p> <p>2. On 1-27-14 the nurse managers completed an audit of staff providing personal cares and monitored for hand washing being performed as required and concerns were addressed as needed.</p>	2/17/14

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NAME OF PROVIDER OR SUPPLIER  <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>		
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F 441	<p>Continued From page 66</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview and facility policy review it was determined the facility failed to ensure staff performed handwashing in an accepted professional manner while performing resident care. This was true for all residents on the 200 hall. The deficient practice had the potential to cause more than minimal harm when 2 CNA's were observed to provide cares for Resident #11 and did not wash their hands in between pericare and applying a new brief. Findings include:</p> <p>The facility's "Hand Washing" policy recorded:</p> <p>*Special Considerations:</p> <p>1. Handwashing should occur at a minimum during the following contacts:</p> <ul style="list-style-type: none"> <li>-Before and after direct or indirect resident contact;</li> <li>-Before and after performing any bodily function, such as blowing your nose or using the bathroom;</li> <li>-Before preparing or serving food;</li> <li>-Before preparing or administering medications; and</li> <li>-After direct or indirect contact with a resident's excretions, secretions, or blood.</li> </ul> <p>1. On 1/13/14 at 10:50 am CNA #4 and CNA #5 were observed providing pericare for Resident #11. Both CNA's were observed to unfastened each side of the brief and tuck the front of the brief between the resident's legs into the periaerea. CNA #4 with gloved hands took a wipe and wiped the front periaerea. With the soiled gloves she assisted in turning the resident onto her left side.</p>	F 441	<p>3. On 1-15-14 Nursing staff were re-educated by the Director of Nursing on required hand washing while providing personal cares. Resident #11 direct care providers were re-educated on 1/15/14 by the Director of Nursing on required hand washing and infection control practices.</p> <p>4. Beginning the week of 2-17-14 the nurse managers will complete audits of hand washing and infection control weekly for 4 weeks and monthly for 2 months</p> <p>and quarterly thereafter to ensure required infection control practices are being followed and required hand washing is occurring with cares. 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. The Director of Nursing is responsible for monitoring and follow-up.</p> <p style="text-align: right;">Date of compliance 2/17/14</p>		

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F 441	<p>Continued From page 67</p> <p>The resident was incontinent of stool. CNA #4 began taking wipes out of the container that was on the bedside stand, and cleaned the stool from the resident's buttocks. When this was completed she rolled the brief up put it in a bag and placed it on the bedside table. With the soiled gloves she took a new brief off the bedside stand placed it under the resident and assisted in rolling the resident from side to side. When the brief was in place, with the soiled gloves she assisted in pulling up the resident's pants and placing the Hoyer lift pad under the resident. Then CNA#4 removed the gloves, put the gloves in the bag with the brief, put on new gloves and continued cares for the resident.</p> <p>2. On 1/13/14 at 2:15 pm CNA#1 was observed to provide pericare for Resident #11. The CNA was observed to remove the brief and tuck the brief between the resident's legs into the periaarea. The resident was incontinent of urine. With the soiled gloves the CNA tried to assist the resident onto her left side. The bed was not locked. She locked the bed. The CNA with the soiled gloves pushed the resident up to her left side cueing the resident to grab the bar on the left side of the bed. With the soiled gloves the CNA obtained wipes from the container on the bedside table, and cleaned the buttocks of the resident. With the soiled gloves the CNA placed a new brief under the resident, the resident rolled on to her back. The CNA cleaned the periaarea, closed the lid of the wipes and put the wipes back in the drawer of the bedside table. Continuing with the soiled gloves she assisted the resident in rolling side to side to fasten the brief. When the brief was in place the CNA pulled up the resident's pants and straightened the resident in the bed. The CNA removed the soiled gloves and put on new ones.</p>	F 441		
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F 441	Continued From page 68 When it was brought to the CNA'S attention that she had used the soiled gloves for caring for the resident she agreed and stated, "yeh."  On 1/16/14 at 5:00 pm the Administrator and the DON were informed of the findings. No additional information was provided.	F 441			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/17/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>TRINITY MISSION HEALTH &amp; REHAB OF HOLL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 12TH AVENUE ROAD NAMPA, ID 83686</b>
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C 000 16.03.02 INITIAL COMMENTS

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.

The following deficiencies were cited during the annual State Licensure and complaint survey of your facility.

The surveyors conducting the survey were:  
Arnold Rosling, RN, BSN, QMRP, Team Coordinator  
Bradley Perry, BSW, LSW  
Lauren Hoard, RN, BSN  
Susan Gollobit, RN  
Jana Duncan, RN, MSN

The survey team entered the facility on Monday, January 13, 2014 and exited the facility on Friday January 17, 2014.

C 000

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

**RECEIVED**  
**FEB 10 2014**  
**FACILITY STANDARDS**

C 123 02.100,03,c,vii Free from Abuse or Restraints

vii. Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient/resident from injury to himself or to others;

This Rule is not met as evidenced by:  
Refer to F221 as it relates to using physical restraints.

C 123

*Please Refer to F221 POC*

*2-17-14*

C 125 02.100,03,c,ix Treated with Respect/Dignity

C 125

*Please Refer to F.164 and F241 plan of Correction*

*2-17-14*

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Manish* Administrator *2-7-14*

Bureau of Facility Standards

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C 125	Continued From page 1  ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F164 regarding a resident's medical issues being discussed where others could hear. Refer to F241 regarding resident's bodies exposed while in the hallway and a cook shouting food order clarification with residents' in the dining room.	C 125		
C 147	02.100,05,g Prohibited Uses of Chemical Restraints  g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician. This Rule is not met as evidenced by: Please refer to F-329 as it refers to unnecessary drugs	C 147	Please Refer to F 329 P.O.C.	2-17-14
C 316	02.107,07,c,ii Food Service for Residents with Restrictions  ii. Special attention shall be given to the food given patients/residents without dentures, with poor dentures, or with poor teeth because of the difficulty these	C 316	Please refer to F 365 P.O.C.	2-17-14

Bureau of Facility Standards

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C 316	Continued From page 2 patients/residents have with mastication. This Rule is not met as evidenced by: Please refer to FTag 365. The resident was served food that had the potential to cause gasrtic upset and was not her preference.	C 316		
C 644	02.150,01,a,i Handwashing Techniques  a. Methods of maintaining sanitary conditions in the facility such as:  i. Handwashing techniques. This Rule is not met as evidenced by: Refer to FTag 441 as it relates to handwashing.	C 644	<i>please refer to F 441 P.O.C.</i>	<i>2-17-14</i>
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting attendance records, it was determined the facility did not ensure the Housekeeping Representative and Pharmacist attended/participated in quarterly ICC meetings. This failure created the potential for a negative affect for all residents, staff, and visitors in the facility when ICC members were not involved in the ICC meetings. Findings included:  On 1/16/14 at 2:05 p.m., the DON, who was the designated Infection Control Nurse, was interviewed about the Infection Control Program.	C 664	State tag 664  1. Infection Control reports for the month of January 2014 were reviewed, discussed and signed off on by the IDT which included the Housekeeping Supervisor and the Pharmacist. 2. On 1-20-14 the Administrator audited the Infection Control participants and sign in sheets to ensure that Housekeeping and Pharmacy are in attendance and is signing the attendance log and concerns were addressed as needed.	<i>2-17-14</i>

Bureau of Facility Standards

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C 664	<p>Continued From page 3</p> <p>The DON was asked to provide attendance records for 3 consecutive months of ICC meetings.</p> <p>On 1/16/14 at 3:00 p.m., the DON provided 4 consecutive ICC meeting attendance records dated September 2013, October/November 11/22/13 and 12/20/13.</p> <p>The attendance records documented the staff who attended the aforementioned ICC meetings, but the Pharmacist and Housekeeping Representative were not on the list.</p> <p>On 1/16/14 at 3:05 p.m., the DON was asked if the Pharmacist attended the ICC meetings at least quarterly. She said the Pharmacist goes over information from the meetings with the facility when something needs to be reviewed. The DON added the facility will call the Pharmacist if there is a concern. When asked why the Housekeeping Representative was not present for the aforementioned meetings, the DON stated, "She usually attends. I don't know why."</p> <p>On 1/16/14 at 4:30 p.m., the Administrator and DON were informed of the ICC meeting attendance issue. However, no further information or documentation was provided.</p>	C 664	<p>3. On 1-24-14 Housekeeping supervisor and Pharmacy Consultant were re-educated by the Administrator on the need to attend the facility Infection Control meeting and signing the attendance record</p> <p>4. Beginning the week of 2/17/14 the Administrator or designee will complete monthly audits of Infection control meeting of who is attending, monthly for 3 months then quarterly and quarterly thereafter to ensure that Housekeeping and Pharmacy are in attendance and signing attendance sheets. 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 and monitoring are needed at that time. The Administrator is responsible for monitoring and follow-up.</p> <p>Date of compliance 2-17-14</p>	
C 680	<p>02.151,03,e Encouragement to Participate</p> <p>e. Provide active and continuing encouragement of patients/residents to participate in individual or group activities.</p> <p>This Rule is not met as evidenced by: Please refer to FTag 248. Resident was not being</p>	C 680	<p><i>C-680 Please Refer to F248 P.O.C.</i></p>	<p><i>2-17-14</i></p>

Bureau of Facility Standards

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C 680	Continued From page 4 assisted to the activity the resident preferred.	C 680		
C 747	02.200,01,e Individualized Resident Care Plan  e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision; This Rule is not met as evidenced by: Please refer to F278 as it relates to accurate MDS assessments.	C 747	<i>Please refer to F278 P.O.C.</i>	<i>2-17-14</i>
C 781	02.200,03,a,iii Written Plan, Goals, and Actions  iii. Written to include care to be given, goals to be accomplished, actions necessary to attain the goals and which service is responsible for each element of care; This Rule is not met as evidenced by: Refer to F280 as it relates to written care plan.	C 781	<i>Please refer to F280 P.O.C.</i>	<i>2-17-14</i>
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to not following the care plan for a resident with dementia.	C 784	<i>Please refer to F309 P.O.C.</i>	<i>2-17-14</i>

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C 789	Continued From page 5	C 789		2-17-14
C 789	02.200,03,b,v Prevention of Decubitus  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 regarding conflicting care plans for pressure sore prevention and pressure sore prevention care plan not followed.	C 789	<i>Please refer to F 314 P.O.C</i>	
C 790	02.200,03,b,vi Protection from Injury/Accidents  vi. Protection from accident or injury; This Rule is not met as evidenced by: Please see F 323 as it pertains to accident hazards.	C 790	<i>Please refer to F 323 PDC</i>	2-17-14
C 804	02.200,04,g Recorded on Medication Record  g. Each patient's/resident's medication is properly recorded on his individual medication record by the person administering the medication. The record shall include: This Rule is not met as evidenced by: Please refer to FTag 281. 2 LN signed the Medication Administration Record after dispensing the medication, and prior to giving the medications to the resident.	C 804	F281 <i>C-804</i>  1. On 1-28-14 Residents residing on 100hall and 200 halls were assessed by the Director of Nursing regarding medication administration and no concerns were noted.  2. On 1-24-14, the nurse managers completed medication pass audit on 100, 200, 300, 400, 500 halls to ensure that required signing of medication that is prescribed is being followed and no concerns were noted.	2-17-14
C 835	02.201,02,i Meds in Possession of Resident Limitations	C 835	3. The Licensed Staff were re-educated on 1-15-14, by the Director of Nursing on medication pass and the required signing of medication administration to the resident.	

Bureau of Facility Standards

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C 835

Continued From page 6

i. No medication shall be in the possession of the patient/resident unless specifically ordered by the physician on the patient's/resident's medical record, and in no case shall exceed two (2) units of dosage. All such medications shall be individually packaged by the pharmacist in units of dose, labeled with the patient's/resident's name, unit of dose, and date of distribution. The charge nurse shall maintain an inventory of these drugs on the patient's/resident's medical record.

This Rule is not met as evidenced by: Refer to F176 as it relates to self administration of medications.

C 835

4. Beginning the week of 2-17-14 the Nurse Managers will complete 3 audits weekly of medication passes weekly for 4 weeks and monthly for 2 months and quarterly thereafter to ensure required signing of administration of medication is being followed. 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. The Director of Nursing is responsible for monitoring and follow-up.

Date of compliance 2-17-14

*C-835 Please refer to F176 P.D.C 2-17-14*



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 208-334-8626  
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January 30, 2014

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

Provider #: 135094

Dear Ms. Brutsman:

On **January 17, 2014**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LLC. Arnold Rosling, R.N., Q.M.R.P., Lauren Hoard, R.N., Susan Gollobit, R.N., Bradley Perry, L.S.W. and Jana Duncan, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on January 13 - 17, 2014.

The medical records of the nineteen residents, including the identified resident, were reviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00005864**

**ALLEGATION #1:**

The complainant stated an identified resident was transferred to this facility from another facility. While at this facility, he was transferred to the hospital, and the resident's wife was not notified.

**FINDINGS:**

According to the record, the resident was admitted to the facility on November 8, 2012. The Admission Face Sheet included a note next to the section entitled Contact Information that stated, "Wife requested staff call back if does not answer on first call."

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 2 of 2

The resident was sent to the hospital on November 28, 2012, at 4:45 p.m., due to an increased blood glucose level and a decrease level of consciousness. The order documented that the residents' family member was called on two different occasions without an answer.

The medical record further documented that the Director of Nursing (DoN) and the social worker talked with the family member at 3:30 p.m. about the resident's advanced directives and his refusals of care and medications. No decision was made at that time by the family member. Nursing notes documented the resident's declining condition throughout the day. The resident became unresponsive with a blood glucose level of 464.

The DoN and the social worker called the family member on December 5, 2012, due to rumors that the family was unhappy with the resident's care. The social worker attempted to identify the family's issues with the care so the facility could correct them. The documentation included a conversation about staff trying to contact the family member. There was no resolution as the family member hung up on them.

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



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February 13, 2014

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

Provider #: 135094

Dear Ms. Brutsman:

On **January 17, 2014**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LLC. Arnold Rosling, R.N., Q.M.R.P., Susan Gollobit, R.N., Lauren Hoard, R.N., Bradley Perry, L.S.W. and Jana Duncan, R.N. conducted the complaint investigation. The complaint was investigated during a standard Recertification and State Licensure survey, conducted by five surveyors over five days. The survey team reviewed medical records and interviewed residents, families and staff.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006057**

**ALLEGATION #1:**

The resident was admitted to the facility for a brief rehab stay following surgery.

Complainant stated that the family could not get information from the facility as to when the resident was scheduled with a follow-up appointment with her surgeon or urologist. When they asked the nursing staff, they were told they would have to talk to the van driver to get that information.

**FINDINGS:**

Staff confirmed that the van driver makes the appointments and has them in a scheduling book.

The rationale is so there is no conflict with scheduling residents for appointments or with getting residents to their appointments.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Complainant stated the resident was on Metformin at home, with blood glucose levels (BGs) still in the 200 range. Metformin was not ordered for the resident at the facility. Complainant states that when a concerned family member addressed this with nursing staff, she did not get an answer. Complainant expressed concern that the resident's diabetes is not managed in the facility.

FINDINGS:

Review of the medical record revealed the resident did not receive Metformin for her diabetes. On April 15, 2013, the physician ordered Levemir 25 units subcutaneous every morning. The physician also ordered the resident's blood glucose to be tested every six hours. This was changed on April 29, 2013, to test the resident before every meal and at hour of sleep (HS). The documentation shows the facility was in compliance with these orders.

The resident's glucose testing showed the resident was in fair control. There were six times the resident's glucose was over 200. The resident's glucose levels fluctuated, but usually ranged from 110 to 140.

The Administrator and DoN did not know why the family member did not get an answer. The family member was at the resident's care conference, and the documentation in the record shows that multiple issues were discussed.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Complainant states there was not an organized discharge process from the facility.

3-1 Complainant states the family was originally told there would be weekly meetings to discuss discharge, but those meetings did not take place.

3-2 Complainant states at one point a family member was told the resident would have to be

discharged by May 10, 2013, due to insurance purposes.

- 3-3 Complainant states on May 7, 2013, a family member was informed by three physical therapists that the resident was not ready to go home and needed an extended rehab stay. Then on May 9, 2013, the family member was told the resident was ready for discharge.
- 3-4 The complainant stated that for the next week after May 9, 2013, the family member repeatedly tried to contact nursing, social work, therapy and the administrator to get more, specific information about discharge but did not get a response.
- 3-5 Complainant states that on May 17, 2013, a family member was on the phone with the administrator voicing these concerns and receiving reassurance from the administrator that communication with the facility would improve. The complainant states as the family member was speaking with the administrator, a call "buzzed through" on her second line. The call was from the resident stating she was being discharged that day and needed a ride home.
- 3-6 The complainant states that neither the resident nor her family was educated on colostomy care prior to discharge. Even though the colostomy was new, no supplies were sent home with the resident, and no arrangements for supplies were made. The resident was sent home with no medications and no prescriptions even though she was on different medications than she had been at home and even though she was on an anti-biotic that had not been completed. No discharge instructions were provided. The complainant states the family had to contact the physician, the home health agency and make two trips to the pharmacy, after the resident got home to make sure everything was in place.

#### FINDINGS:

- 3-1 The medical record did not include any documentation that the facility would meet weekly to discuss discharge. The Business Office Manager (BOM), Administrator and Social Service staff were interviewed on January 16, 2014, at 10:30 a.m. The resident had a managed care insurance plan that required weekly information for justifying the resident's stay in the facility. The BOM indicated she was in contact with the resident's insurance company to receive the extensions the resident needed, so the family would not be burdened with the task. A family member was at the April 22, 2013, Resident Care Conference and it was documented that the facility "will do colostomy training with family and PCS provider." The facility's staff could not remember why these were not scheduled. The resident was receiving training by nursing and therapy staff on colostomy care and documented as independent in caring for it on her own. The resident was discharged home with home health that included therapy.

- 3-2 It seems likely that the family may have been told this. The resident's managed care insurance plan probably told the facility they would not cover the resident after a certain date. The BOM provided information to the carrier that the resident was still in need of therapy, so the resident received an extension.
- 3-3 On May 7, 2013, the resident still was not ready to go home. The resident's stay was extended and on May 17, 2013, when the resident went home, she still had days left for her to receive therapy. The resident told the facility she wanted to go home on that date. The BOM indicated the resident would have a copay after May 17, 2013, to pay and assumed that was the reason she wanted to go home. Other than this reason, there was no documentation as to why this decision was made by the resident.
- 3-4 The Administrator, BOM and social worker did not know why the family member could not get in contact with them. In the complaints allegation #5, the complainant indicated a family member was talking to the Administrator on May 17, 2013, when the resident called. The managed care insurance plans are difficult to pinpoint a discharge date due to the requirements for frequent extensions.
- 3-5 The BOM stated in an interview on January 16, 2014, at 10:30 a.m., the resident had time left on the extension from the insurance company. The BOM also said the resident made the choice to leave, the resident wanted to go home before the co-pay started. The discharge was hurriedly put together as a result. The resident was able to care for the colostomy independently and the facility was able to arrange for in home care.
- 3-6 The resident's medication prescriptions were sent to the resident's pharmacy of choice. The facility does not send any medications home with a resident

The May 17, 2013, Discharge Summary did not have a lot of information on it, but it did have summaries of all the departments that the resident had contact with.

The nursing notes on May 14, 2013, at 2:30 p.m. documented "Works with therapy goal is to DC home Friday." A Nursing Note dated May 17, 2013, at 12:30 p.m. documented "(Patient) (discharged) home (with) all belongings... Received 1 box of Ostomy appliances. Escorted (patient) to private car. Pharmacy called with meds - faxed physician order to pharm(acy)...."

The resident was independent with caring for her colostomy. The occupational therapist (OT) had the Ostomy as part of goals they were working on. The May 17, 2013, OT discharge summary documented "Impact on Burden of Care/Daily Life: Patient has progressed in all areas and is no longer dependent upon caregiver for toileting, Ostomy bag care, dressing or basic grooming and hygiene."

Monica K. Brutsman, Administrator  
February 13, 2014  
Page 5 of 5

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 cursive script that reads "Loretta Todd". The signature is written in black ink and is positioned above the printed name.

LORETTA TODD, R.N. Supervisor  
Long Term Care

LT/dmj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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January 30, 2014

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Dear Ms. Brutsman:

On **January 17, 2014**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LLC. Arnold Rosling, R.N., Q.M.R.P., Lauren Hoard, R.N., Susan Gollobit, R.N., Bradley Perry, L.S.W. and Jana Duncan, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on January 13 - 17, 2014.

The following observations were conducted:

- Every residents' room and throughout the facility from January 13 - 17, 2014;
- Bathrooms were observed in every residents' room from January 13 - 17, 2014;
- Sixteen residents' beds were observed from January 13 - 17, 2014; and
- Several housekeepers were observed cleaning residents' rooms from January 13 - 17, 2014.

The following documents were reviewed:

- The facility's grievance files;
- Resident Council meeting minutes October 2013 - January 2014; and
- The facility's housekeeping Sanitized/Cleaned room audit sheet.

The following interviews were completed:

- Eight residents were interviewed at a group interview regarding facility smells and the

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 2 of 5

- cleanliness of their rooms and the facility;
- Four individual residents were interviewed regarding smells and overall cleanliness of their rooms and the facility;
- Two resident's family members were interviewed regarding facility smells and overall cleanliness;
- Two housekeepers were interviewed regarding how rooms were cleaned;
- The Housekeeping Supervisor was interviewed about how she checked the work of the housekeepers; and
- The Director of Nursing was interviewed regarding how she ensured staff made residents' beds daily.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006072**

**ALLEGATION #1:**

The complainant stated they have visited the facility weekly since February 2013 and have noticed smells of urine and bowel movement (BM) in an identified resident's room and in the facility in general.

**FINDINGS:**

The identified resident was no longer residing in the facility at the time the complaint was investigated.

During the initial tour and throughout the remainder of the survey, urine and BM odors were not detected in residents' rooms or in the facility as a whole.

The facility's grievance files and resident council minutes did not reveal that smells were an issue in the facility. The facility provided a cleaning audit checklist, which was initiated in the facility on September 1, 2013.

The eight residents interviewed at the group interview about facility smells, specifically urine and BM, said, it was not an issue.

The four residents interviewed regarding smells said, it was not an issue.

The two resident's family members interviewed about facility smells said it was not an issue.

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 3 of 5

The two housekeepers interviewed about how rooms are cleaned said, that each room is cleaned according to the checklist they were trained on. They also said that if they identify a urine or BM smell, they would track down the cause of the problem and clean or fix the issue.

The Housekeeping Supervisor interviewed about how she checks the work of the housekeepers said, she spot checks rooms daily and often works alongside her staff to ensure smells are not present. She also said that the checklist the housekeepers use is reviewed to make sure work is being completed.

Although the incident may have occurred as described, based on observations, records reviewed and residents, family and staff interviews, the allegation could not be verified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The complainant stated that on June 6, 2013, an identified resident was taken out of the facility in the morning and returned in the late afternoon. The complainant also stated that when the resident came back, the resident's bed was not made.

**FINDINGS:**

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Throughout the survey from January 13 - 17, 2014, sixteen residents' beds were observed. The beds observed were made whenever residents were not in them and under the covers.

The facility's grievance files and resident council minutes did not reveal that a bed being made was an issue in the facility.

A resident interviewed about the bed being made said, it was not an issue.

A resident's family member interviewed about beds being made said it was not an issue.

The Director of Nursing interviewed about the process for staff making beds said, resident beds were made daily, in the morning, after residents were up for the day. She also said linens were changed at least twice a week, when residents were showered or bathed and as needed.

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 4 of 5

Although the incident may have occurred as described, based on observations, records reviewed and residents, family and staff interviews, the allegation could not be verified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The complainant stated that an identified resident's bathroom was dirty, and dirt was found under the sink and in the corners of the bathroom.

**FINDINGS:**

The identified resident was no longer residing in the facility at the time the complaint was investigated.

During the initial tour and throughout the remainder of the survey, bathroom cleanliness was observed and bathrooms were found to be cleaned adequately.

The facility grievance files and resident council minutes did not reveal that bathroom cleanliness was an issue. The facility provided a cleaning audit checklist, which was initiated in the facility on September 1, 2013.

At a group interview of eight residents, residents were interviewed regarding bathroom cleanliness; the residents said it was not an issue.

Four residents interviewed individually if the bathrooms were clean said, it was not an issue.

Two resident's family members interviewed regarding bathroom cleanliness reported it was not an issue.

The two housekeepers interviewed regarding how bathrooms are cleaned said, each room and bathroom are cleaned according to the checklist they were trained on.

The Housekeeping Supervisor interviewed about how she checks the work of the housekeepers said, she spot checks rooms daily and often works alongside her staff to ensure bathrooms are cleaned. She also said the checklist the housekeepers use is reviewed to make sure work is being completed.

Although the incident may have occurred as described, based on observations, records reviewed

Monica K. Brutsman, Administrator  
January 30, 2014  
Page 5 of 5

and residents, family and staff interviews, the allegation could not be verified.

**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 signature is written in a cursive, slightly slanted style.

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

LKK/dmj