



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 4044 7236

May 6, 2013

Sherrie L. Nunez, Administrator
Trinity Mission Health & Rehab of Midland, LLC
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **April 25, 2013**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Trinity Mission Health & Rehab of Midland, LLC by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 3). Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance. WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION.** After each deficiency has been answered and dated, the administrator should

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 20, 2013**. Failure to submit an acceptable PoC by **May 20, 2013**, may result in the imposition of civil monetary penalties by **June 10, 2013**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **May 30, 2013 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 30, 2013**. A change in the seriousness of the deficiencies on **May 30, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2013** includes the following:

Denial of payment for new admissions effective **July 25, 2013**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 25, 2013**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

Sherrie L. Nunez, Administrator
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If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 25, 2013** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **May 20, 2013**. If your request for informal dispute resolution is received after **May 20, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

LKK/dmj
Enclosures

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

PRINTED: 05/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/25/2013
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification and complaint investigation survey of your facility. The surveyors conducting the survey were: Lorraine Hutton RN, QMRP, Team Coordinator Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN Survey Definitions: CNA = Certified Nurse Aide DNS/DON = Director Nursing Services/Director of Nursing SCU = Special Care Unit	F 000	Preparation and submission of this plan of correction by, Trinity Mission Health & Rehab of Midland , does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. 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 room for each resident. 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. 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.	F 164	F164 1. On 4/26/2013, Resident #1 was assessed by the Licensed Social Worker with no negative psychosocial well-being concerns noted. On 4/22/2013 the privacy curtain was replaced by the Housekeeping Director.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 5/1/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</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 ensure personal privacy while providing personal cares for 1 of 11 (# 1) sampled residents. Exposure to roommates during personal care created the potential for psychosocial harm for the resident. Findings include:</p> <p>Resident #1 was admitted to the facility on 12/24/08 with diagnoses of dementia with behavior disturbance, cerebral vascular accident, anorexia, contracture of the hand and depressive disorder.</p> <p>The resident's most recent Significant Change MDS documented the resident had long and short term memory issues and moderate impairment with decision making skills. The resident required extensive assistance for transfers, dressing, and personal hygiene.</p> <p>On 4/22/13 at 11:05 a.m. staff was observed to check the resident for incontinence. The resident was in her room in bed. The resident's two roommates were in the room in their wheelchairs waiting to go out to lunch. CNA #1 pulled the privacy curtain around Resident #1's bed, but it</p>	F 164	<p>2. On 4/22/2013 an audit was completed by the Administrator and Housekeeping Director of privacy curtains to ensure personal privacy is maintained during care; noted concerns were addressed on 4/22/2013.</p> <p>On 5/10/2013 observations were completed by the Staff Development Coordinator for residents' privacy being maintained with no additional concerns noted.</p> <p>On 5/10/2013 interviews with residents were conducted by the Social Service Director related to privacy being maintained; no concerns were reported.</p> <p>3. On 4/22/2013 facility staff was re-educated by the Staff Development Coordinator on ensuring personal privacy being maintained during care.</p> <p>On 4/22/2013 the Maintenance Director was re-educated by the Administrator on the requirements of maintaining privacy and ensuring privacy curtains provide privacy for care.</p>	

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F 164	Continued From page 2 was 4 feet to short and did not reach all the way to and around the bottom of the bed. The CNA indicated that there were hooks for the other curtain that had been taken down and not replaced. This resulted in the resident's area not being covered to prevent her roommates from seeing staff provide cares. The DON was informed at 11:15 a.m. The facility replaced the curtain by the time the resident returned from lunch at 1:00 p.m.	F 164	4. Beginning the week of 5/25/2013, three audits will be completed by the Administrator or designee weekly for 4 weeks and monthly for 2 months to ensure that residents' personal privacy is maintained during care. A report will be submitted to the Quality Assurance committee for 3 months. The Quality Assurance committee will review and determine if further interventions are needed at that time. The Administrator or designee is responsible for monitoring and follow-up Date of compliance: 5/25/2013	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to ensure the flooring, baseboards, and wall panels were maintained in a cleanable and attractive manner, and the bathroom and dining room ceiling fans were kept clean. This effected 10 of 14 resident rooms (#s 203, 206, 208, 301, 305, 312, 318, 319, 323 & 324), 1 of 3 dining rooms (SCU dining room), and 1 of 2 community TV (Television) lounges. Findings include: 1. During tours of the facility on 4/22/13 at 1:30 pm, 4/23/13 at 3:15 pm, and 4/25/13 at 9:15, the floors in the following rooms were observed to have torn and/or worn linoleum and un-cleanable gaps along seam lines: * 305 - Linoleum in the bathroom had a large u-shaped darkened area around the toilet	F 253		
			1. By 5/25/2013 the floors in room 305 will be replaced by an outside contractor. By 5/25/2013 the floors in room 318 will be replaced by an outside contractor. By 5/25/2013 the floors in room 319 will be replaced by an outside contractor.	

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F 253	<p>Continued From page 3</p> <p>measuring approximately 2 feet long by 1 foot wide. The darkened area made the floor look dirty and/or stained. In addition, there was a gap in the floor seam at the door entering the bath room which measured approximately ¼ inch wide. Note: The Administrator and the Maintenance Supervisor, who accompanied the surveyor on the 4/25/13, tour stated the area surrounding the toilet, was not dirty. The darkened area was either a build up of wax or staining from the industrial cleaner used frequently to clean up urine from this area.</p> <p>* 318 - The floor seam between the room and the adjacent bathroom appeared dirty with a 3 inch long by ¼ inch wide gap. The floor between beds 2 and 3 had multiple long black scuff marks and 3 small areas, measuring approximately 3 inches long by 2 inches wide, of torn linoleum. In addition, there was a 2 foot long by 6 inches wide worn area between the window and bed 3. The worn area was dark, appeared thinned, and had small tears.</p> <p>* 319 - There were gaps in the 3 floor seams that ranged from 3 to 5 inches long to 1/8 to 1/4 inches wide. This left the areas rough, non-cleanable, and not homelike. In addition, there was a 1 inch round hole in the linoleum at foot of the 3rd bed.</p> <p>* 323 - There was a 7 inch long by 3 inch wide linoleum patch, in front of the radiator, that was lifting away from the floor.</p> <p>There were similar findings of torn linoleum, gaps in seams, and worn floors in rooms 203, 206, 208, 301, and 312</p> <p>2. During an environmental tour of the building on 4/22/13 at 1:30 pm, the wooden baseboard trim along the right wall entering the TV lounge on the 300 hall, had multiple areas that were worn,</p>	F 253	<p>By 5/25/2013 the floors in room 323 will be replaced by an outside contractor.</p> <p>By 5/25/2013 the floors in room 203 will be replaced by an outside contractor.</p> <p>By 5/25/2013 the floors in room 206 will be replaced by an outside contractor.</p> <p>By 5/25/2013 the floors in room 208 will be replaced by an outside contractor.</p> <p>By 5/25/2013 the floors in room 301 will be replaced by an outside contractor.</p> <p>By 5/25/2013 the floors in room 312 will be replaced by an outside contractor.</p> <p>By 5/25/2013 the wooden baseboard trim along the right wall entering the TV lounge on the 300 hall will be repaired by an outside contractor.</p>	

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F 253	Continued From page 4 scuffed, and missing paint. The areas ranged from 1 inch long to 3 inches wide and 2 inch long and 1 inche wide. In addition, the wooden wheel chair guard to the left of the entrance of the TV lounge was also missing paint and scuffed. 3. During a tour of the Big Band dining room on 4/22/13 at 2:15 pm, 6 leather panels were noted under the windows to the left of the entrance. Each panel was lined with decorative metal brads. The brads on the bottom corners of the panel were loose and visibly lifting away from the wall on 5 of the 6 panels. 4. During the environmental tour on 4/25/13 at 9:15 am, ceiling fans/vents in the bathrooms in rooms 301 and 323 were full of dust. This was observed when the lights were turned on and a large amount of dust could be viewed between the slats and the vent louvers. Each of the fans/vents were in the middle of the ceilings approximately 12 inches in front of the toilet. The Administrator, Maintenance Supervisor, and Corporate Regional Director (CPD), accompanied the surveyor during this tour. The Administrator and CPD stated that the facility was targeted for major renovation in which the floor would be replaced and other issues addressed. They stated the schedule for the renovation and the resolution of the other issues would be addressed in their POC (Plan of Correction). 5. During tour of the special care unit on 4/24/13 at 8:55 a.m., an exhaust vent was noted in the ceiling in the center of the activity/dining area. The vent was about 18 inches by 18 inches and was about 3 inches deep. The vent had louvers on four sides. The vent appeared to have a buildup of dust, chipped paint and debris hanging from the louvers. This vent was over the tables that residents used during meal time. At 9:30	F 253	By 5/25/2013 the wooden wheelchair guard to the left of the entrance of the TV lounge will be repaired by an outside contractor. On 4/29/2013 the Big Band Dining room leather panels were removed and the wall was re -painted by the Maintenance Director. By 5/25/2013 the ceiling fans and vents in the bathroom of 301 will be replaced by an outside contractor. By 5/25/2013 the ceiling fans and vents in the bathroom of 323 will be replaced by an outside contractor. On 4/24/2013 the exhaust vent in the Special Care Unit was removed, cleaned, re-painted and replaced by the Housekeeping Director. By 5/25/2013 the bathroom fans and vents in room 325 will be replaced by an outside contractor.		

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F 253	<p>Continued From page 5</p> <p>a.m. the housekeeping supervisor was notified of the unsanitary condition of the vent. The vent was removed, cleaned, repainted and replaced prior to the end of the day.</p> <p>6. During the initial tour of the facility on 4/22/13 at 8:10 a.m. the bathroom fans and vents in the bathrooms of rooms 325 and 326 were noted to have dust buildup and noisy fans. When the light switch was turned on in the bathrooms the fans would startup. The fans were noisy and vibrated loud enough they could be heard in the rooms when the door was closed. It was noted that several of the slats to the vent louvers were broken and there was dust buildup on the vents.</p> <p>The Administrator, Maintenance Supervisor, and Corporate Regional Director, accompanied the surveyor during an environmental tour on 4/25/13 at 9:15 am. They were notified during the tour that the bathroom fans were loud/noisy. The CRD commented that all fans were scheduled to be replaced in an upcoming renovation of the building.</p>	F 253	<p>By 5/25/2013 the bathroom fans and vents in room 326 will be replaced by an outside contractor.</p> <p>2. On 5/1/2013 the Administrator and Maintenance Director completed environmental rounds to ensure that there were no other environmental concerns in need of repairs; no additional concerns noted.</p> <p>3. On 5/9/2013 the facility staff was re-educated by the Staff Development Coordinator regarding maintaining a sanitary, orderly, and comfortable interior.</p> <p>On 5/10/2013 the Maintenance Director was re-educated by the Administrator on the requirements of maintaining a sanitary, orderly, and comfortable interior.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDL		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
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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 licensure survey and complaint investigation of your facility. The surveyors conducting the survey were: Lorraine Hutton RN, QMRP, Team Coordinator Arnold Rosling, RN, BSN, QMRP Amy Jensen, RN	C 000	4. Beginning the week of 5/25/2013 three audits will be completed by the Administrator or designee weekly for 4 weeks and monthly for 2 months to ensure that there are no interior or environmental concerns in need of repair. 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 Administrator is responsible for monitoring and follow-up Date of Compliance: 5/25/2013	
C 362	02.108,07,a Interior Surfaces Kept Clean & Sanitary a. Floors, walls, ceilings, and other interior surfaces, equipment and furnishing shall be kept clean, and shall be cleaned in a sanitary manner. This Rule is not met as evidenced by: See F253 as it relates to interior cleaning of surfaces and equipment.	C 362		
C 386	02.120,03,a Building/Equipment in Good Repair a. The building and all equipment shall be in good repair. This Rule is not met as evidenced by: Please refer to F 253 as it relates to flooring, baseboards, and wall panels in disrepair.	C 386		
C 493	02.121,05,d,x Meet Requirements for Use of Cubicle Curtains x. Cubicle curtains of fire	C 493		

Bureau of Facility Standards



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

TITLE

NHA

(X6) DATE

5/17/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/25/2013
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 493	Continued From page 1 retardant material, capable of enclosing the bed shall be provided in multiple-bed rooms to insure privacy for the patients/residents. Alternatives to this arrangement may be allowed if the alternative provides the same assurance of privacy; This Rule is not met as evidenced by: See F164 as it relates to privacy curtains.	C 493			

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

C362

1. By 5/25/2013 the floors in room 305 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 318 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 319 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 323 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 203 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 206 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 208 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 301 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 312 will be replaced by an outside contractor.

By 5/25/2013 the wooden baseboard trim along the right wall entering the TV lounge on the 300 hall will be repaired by an outside contractor.

By 5/25/2013 the wooden wheelchair guard to the left of the entrance of the TV lounge will be repaired by an outside contractor.

On 4/29/2013 the Big Band Dining room leather panels were removed and the wall was re-painted by the Maintenance Director.

By 5/25/2013 the ceiling fans and vents in the bathroom of 301 will be replaced by an outside contractor.

By 5/25/2013 the ceiling fans and vents in the bathroom of 323 will be replaced by an outside contractor.

On 4/24/2013 the exhaust vent in the Special Care Unit was removed, cleaned, re-painted and replaced by the Housekeeping Director.

By 5/25/2013 the bathroom fans and vents in room 325 will be replaced by an outside contractor.

By 5/25/2013 the bathroom fans and vents in room 326 will be replaced by an outside contractor.

2. On 5/1/2013 the Administrator and Maintenance Director completed environmental rounds to ensure that there were no other environmental concerns in need of repairs; no additional concerns noted.
3. On 5/10/2013 the facility staff was re-educated by the Staff Development Coordinator regarding maintaining a sanitary, orderly, and comfortable interior.

On 5/10/2013 the Maintenance Director was re-educated by the Administrator on the requirements of maintaining a sanitary, orderly, and comfortable interior.

4. Beginning the week of 5/25/2013 three audits will be completed by the Administrator or designee weekly for 4 weeks

and monthly for 2 months to ensure that there are no interior or environmental concerns in need of repair. 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 Administrator is responsible for monitoring and follow-up

Date of Compliance: 5/25/2013

C 386

1. By 5/25/2013 the floors in room 305 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 318 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 319 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 323 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 203 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 206 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 208 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 301 will be replaced by an outside contractor.

By 5/25/2013 the floors in room 312 will be replaced by an outside contractor.

By 5/25/2013 the wooden baseboard trim along the right wall entering the TV lounge on the 300 hall will be repaired by an outside contractor.

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On 4/24/2013 the exhaust vent in the Special Care Unit was removed, cleaned, re-painted

and replaced by the Housekeeping Director.

By 5/25/2013 the bathroom fans and vents in room 325 will be replaced by an outside contractor.

By 5/25/2013 the bathroom fans and vents in room 326 will be replaced by an outside contractor.

2. On 5/1/2013 the Administrator and Maintenance Director completed environmental rounds to ensure that there were no other environmental concerns in need of repairs; no additional concerns noted.
3. On 5/10/2013 the facility staff was re-educated by the Staff Development Coordinator regarding maintaining a sanitary, orderly, and comfortable interior.

On 5/10/2013 the Maintenance Director was re-educated by the Administrator on the requirements of maintaining a sanitary, orderly, and comfortable interior.

4. Beginning the week of 5/25/2013 three audits will be completed by the Administrator or designee weekly for 4 weeks and monthly for 2 months to ensure that there are no interior or environmental concerns in need of repair. 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 Administrator is responsible for monitoring and follow-up

Date of Compliance: 5/25/2013

C 493

1. On 4/22/2013, Resident #1 was assessed by the Licensed Social Worker with no negative psychosocial well-being concerns noted.

On 4/22/2013 the privacy curtain was replaced by the Housekeeping Director.

2. On 4/22/2013 an audit was completed by the Administrator and Housekeeping Director of privacy curtains to ensure personal privacy is maintained during care; noted concerns were addressed on 4/22/2013.

On 5/10/2013 observations were completed by the Staff Development Coordinator for residents' privacy being

maintained with no additional concerns noted.

On 5/10/2013 interviews with residents were conducted by the Social Service Director related to privacy being maintained; no concerns were reported.

3. On 4/22/2013 facility staff was re-educated by the Staff Development Coordinator on ensuring personal privacy being maintained during care.

On 4/22/2013 the Maintenance Director was re-educated by the Administrator on the requirements of maintaining privacy and ensuring privacy curtains provide privacy for care.

4. Beginning the week of 5/25/2013, three audits will be completed by the Administrator or designee weekly for 4 weeks and monthly for 2 months to ensure that residents' personal privacy is maintained during care. A report will be submitted to the Quality Assurance committee for 3 months. The Quality Assurance committee will review and determine if further interventions are needed

at that time. The Administrator
or designee is responsible for
monitoring and follow-up

Date of compliance: 5/25/2013



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

June 10, 2013

Sherrie L. Nunez, Administrator
Trinity Mission Health & Rehab of Midland, LLC
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **April 25, 2013**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Midland, LLC. Lorraine Hutton, R.N., Arnold Rosling, R.N., Q.M.R.P. and Amy Jensen, R.N. conducted the complaint investigation.

This complaint was investigated in conjunction with a Recertification & State Licensure survey and two other complaints that concluded on April 25, 2013. The records of thirteen residents, including that of the identified resident were reviewed. Interviews were conducted with residents, their families and a variety of staff including the administrator and the Director of Nursing Services (DNS).

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005865

ALLEGATION #1:

The complainant said that at the time of admission, the identified resident could walk with a cane and then with a walker. Starting in November 2012, he suffered a significant decline in ambulation. The facility did not provide rehabilitative or restorative services to prevent the decline; instead, they transferred him to another facility. By that time, he was in a wheelchair. The facility indicated they could not provide rehabilitation due to a lack of funding. However,

Sherrie L. Nunez, Administrator
June 10, 2013
Page 2 of 4

the complainant felt the Veteran's Administration (VA) would have covered those services.

FINDINGS:

The identified resident's medical record indicated the resident was receiving both Medicare and VA benefits as a payment source for the resident. On September 24, 2012, the physical therapist (PT) requested an order from the physician after the resident fell for "Physical Therapy evaluation and treatment three times a week, for one week, for wheelchair positioning and therapeutic activity." The resident completed the therapy on October 1, 2012, and the PT requested an order to discontinue therapy because the resident had met his therapy goals. The resident was seen by the nurse practitioner (NP) on September 20, 2012. The NP documented the resident, "overall moves extremities times 4 (both arms and both legs) and weakness in lower extremities."

The resident was moved to a room closer to the nurses' station (318), which had more supervision, because the resident was standing and attempting to transfer and falling. The resident was transferred to the other facility on November 8, 2012. There were no indications that the resident had any restriction for receiving therapy if there was a need. There was no documentation that the resident had a decline that would have required further therapy.

MDS documentation was reviewed back to when the resident was admitted on October 7, 2010. The documentation for the resident's ability to perform activity of daily living for transfers and walking showed on the March 1, 2012, April 1, 2011 and November 23, 2010, assessments that the resident was a two person transfer and he did not walk in his room or in the hallway. The documented mode of mobility was a wheelchair and there was no documentation that the resident used a walker or a cane. The resident's most recent care plan, documented an onset date of March 18, 2011, that documented the resident moved about the facility utilizing a wheelchair and that he was a two person mechanical lift.

The resident was transferred to another facility on November 8, 2012. Review of the nursing documentation from November 1 to November 8, 2012, did not indicate that the resident's wheelchair mobility had declined in the seven days.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the identified resident had dentures. At some point in October and/or November 2012, he could no longer wear the dentures. He experienced pain related to the poorly

fitting dentures. The facility did not alter his diet so he could eat. The resident lost a significant amount of weight, at least 20% or more.

FINDINGS:

The identified resident's medical record documented the resident weighed 140.6 pounds on May 3, 2012. Six months later, on November 2, 2012, his weight was 132.6 pounds. The resident's weight fluctuated up and down between these two weights over those six months. The resident was on weekly weights during this timeframe. The resident was followed by the Nutritional Patient at Risk committee.

The physician's recapitulation order for November 2012 documented the resident was to receive a "Regular Mechanical soft/thin liquids with 2 to 3 finger foods." The resident also received "Resource 2.0 (a dietary supplement), 120 cc orally five times a day for weight loss." The Interdisciplinary team documented at the resident's care conference meeting on July 5, 2012, that the resident received a "regular mechanical soft diet, nutritionally enhanced meals. Two to 3 finger foods. Half and half blended with yogurt each meal and health shakes with meals, loves bananas and watermelon." The resident was followed by the dietitian for weight loss.

The resident's refusal to eat even with staff and family's encouragement was the dietitian's biggest concern for the resident's weight loss. She had discussions with the family about a feeding tube, but it was declined.

There was no documentation that the resident was no longer using his dentures. He was seen by a Nurse Practitioner on November 2, 2012, for a review of his insulin and there was no indication there were any issues with his dentures at that time.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the facility discharged the identified resident to another facility in November 2012, when he had a further decline (change in his ability to swallow.)

The facility did not want him there any longer and the discharge was done without his wife's permission.

Sherrie L. Nunez, Administrator
June 10, 2013
Page 4 of 4

FINDINGS:

Social Service notes documented that the facility had spoken with the resident's wife about the facility undergoing a remodeling and restructuring process. The notes further documented that the facility was asking some family members to consider transferring to "our sister facility, with the option of the resident returning back to the facility once the remodeling is done." The Social Service notes also documented that on November 2, 2012, the family toured the other facility, found a room and felt the resident would do better at that facility. Social Service noted they would notify the physician and get a transfer order.

The resident was transferred on November 8, 2012. Nursing documented on November 9, 2012, at 11:00 a.m. "family back in to get belongings, thank (thanked) us for the care."

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,



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

LKK/dmj



IDAHO DEPARTMENT OF
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June 10, 2013

Sherrie L. Nunez, Administrator
Trinity Mission Health & Rehab of Midland, LLC
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **April 25, 2013**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Midland, LLC. Lorraine Hutton, R.N., Arnold Rosling, R.N., Q.M.R.P. and Amy Jensen, R.N. conducted the complaint investigation.

This complaint was investigated in conjunction with a Recertification and State Licensure survey and two other complaints that concluded on April 25, 2013. The records of thirteen residents, including that of the identified resident were reviewed. Interviews were conducted with residents, their families and a variety of staff, including the administrator and the Director of Nursing Services (DNS).

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005875

ALLEGATION #1:

The complainant stated the identified resident was admitted to the facility approximately 12 years ago. When a visitor checked on the resident on Saturday, January 19, 2013, the resident was noted to be fully drenched in urine and feces was coming up the resident's back. The resident had sores on her back that needed some attention or lotion.

Sherrie L. Nunez, Administrator

June 10, 2013

Page 2 of 4

When the visitor tried to get help for the resident, it took 45 minutes before anyone was able to provide the resident with necessary care. The charge nurse, identified by first name only, who did come to provide care to the resident after 45 minutes, "reeked of (cigarette) smoke."

In addition, when the concerned party attempted to contact the facility to share his or her concerns about the identified resident's care, the telephone rang numerous times, but no one answered the phone.

FINDINGS:

On Saturday, January 19, 2013, at 7:30 p.m., the family did find the resident in wet pants and socks from an incontinent episode. The facility did complete a "Record of Concern" form on the incident and did a follow-up investigation. As a result of the investigation, the RN on duty was "interviewed and educated" about the incident with expectations that it did not occur again. The incident appeared to be a miscommunication between the nurse to the aides caring for the resident and keeping the resident up after the supper meal to receive her medications.

During the recertification survey, no quality of care issues were identified. Residents were groomed and changed as needed. The staffing ratios calculated were twice the state's minimum requirements for the three-weeks previous to the survey. The staffing for the day of the incident was reviewed and it was the same ratio as found during the on-site survey.

The facility has a new phone system. The phone will ring eight times; if it is not answered then it rolls over to the administrator's cell phone. This was put in place by the parent corporation of the facility. The administrator indicated that at times the phone has rolled to her cell phone, which improves communication with families.

The complaint is substantiated but no citations were written because:

- The event occurred but was isolated and did not result in negative outcome to the resident.
- The singular event did not rise to the level to warrant a citation.
- The facility recognized a problem that put the resident at risk.
- The facility monitored and implemented interventions in accordance with the residents assessed needs and recognized standards of practice.

There was a communication issue within nursing and the investigation into the incident identified the problem. Measures were put in place to correct the problem and the resident's care plan was revised.

The problems with the phone system, which was in the process of being replaced at that time,

Sherrie L. Nunez, Administrator
June 10, 2013
Page 3 of 4

have been resolved. If the phone rings more than ten times, it will forward to the administrator cell phone. There were no quality of care problems identified at the time of the survey.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated that the facility requested a room change for the identified resident (from A hall to B hall) due to a major remodeling project. The remodel has not yet occurred. The complainant agreed to the move and now the facility has requested another room change (from B hall to C hall). The reason for the request was noted to be for remodeling; however, the remodel of the A hall had not yet begun. Since the remodel has not been started, the complainant is concerned about what is going on in the facility.

FINDINGS:

The resident was moved off of the 100 hallway because the facility had plans to remodel the area. Unfortunately, the remodel was put on hold temporarily after the 100 hallway was vacated by all residents. The administrator was interviewed on April 25, 2013, at 8:30 a.m. and indicated that the remodel was still going to occur, but the start date was not known. She indicated that a "walk-through" was done in February 2013 by two designers and contractors.

The regulations only require that notice be given prior to room changes, which was done. The facility's failure to follow through with the remodeling per plan is a customer service issue rather than a violation of a regulation.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated that visitors found the identified resident without the physician's ordered oxygen numerous times.

FINDINGS:

The resident is no longer in the facility. In reviewing the resident's closed record, it could not be determined if the oxygen was in place or not. During the survey, no problems were noted related to oxygen use. The surveyors observed several residents using oxygen, and none were found to

Sherrie L. Nunez, Administrator
June 10, 2013
Page 4 of 4

be off or set incorrectly.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As only one of the complaint's allegations was substantiated, but not cited, 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 style with some loops and flourishes.

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

LKK/dmj



IDAHO DEPARTMENT OF
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June 10, 2013

Sherrie L. Nunez, Administrator
Trinity Mission Health & Rehab of Midland, LLC
46 North Midland Boulevard
Nampa, ID 83651

Provider #: 135076

Dear Ms. Nunez:

On **April 25, 2013**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Midland, LLC. Lorraine Hutton, R.N., Arnold Rosling, R.N., Q.M.R.P. and Amy Jensen, R.N. conducted the complaint investigation.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005926

ALLEGATION #1:

The complainant stated that during the first two weeks of August 2012, an identified resident was observed returning from dialysis treatment at about 1:30 p.m. The resident had a skin tear on his left elbow. When asked what happened, the van driver said the resident must have fallen. The resident stated he had been left in the van for over an hour, was trying to get out of his chair and fell. The incident was reported to the administrator and the DoN (Director of Nursing) who then questioned the van driver. The van driver stated that she had gotten busy and had accidentally forgotten about the resident in the van.

An incident report was written up, which the van driver and a facility nurse had to sign and submit to the administrator. A disciplinary action was written against the van driver for neglect, abuse and failure to obey policy. According to the complainant, the administrator asked the

facility nurse to rewrite the incident report and redact the statements made by the resident. Later that day, the van driver stated her formal disciplinary action was thrown in the trash and nothing would happen.

FINDINGS:

This complaint was investigated in conjunction with a Recertification and State Licensure survey of the facility. However, the dates of all but one of the complainant's allegations fell within the timeframe covered by the facility's annual Recertification and State Licensure survey dated August 10, 2012, and the subsequent follow-up surveys dated October 19, 2012, and December 20, 2012. The facility was given a period of time to correct the cited deficient practices. During the August 10, 2012, Recertification and State Licensure survey the following citations, which addressed similar issues to those identified by the complainant were cited:

- F225 - Failure to thoroughly investigate allegations of abuse and neglect and to report the findings to the state agency.
- F309 - Failure to ensure residents received necessary care and services in accordance with their comprehensive assessments and plan of care.
- F323: Failure to keep residents safe from harm and/or accidents. This deficient practice was cited at a "harm" level during both the August 10, 2012, Recertification and State Licensure survey and the October 19, 2012, On-Site Follow-Up survey.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated in the second half of June 2012 an identified resident was admitted with a diagnosis of a stroke. The resident had PRN (as needed) orders for a bedside suction machine for oral secretions. The administrator refused to get a suction machine as the orders were for PRN. When approached by the facility social worker over the issue of the PRN suction machine, the administrator gave the same response. The speech therapist then went to the administrator and was told that if there was a physician's order for routine suctioning the facility would get a machine for the resident. The facility Nurse Practitioner (NP) was contacted and the NP refused to order routine suctioning over PRN, as this would actually lessen the amount of suctioning the resident would be able to receive. The resident never received a suction machine, and staff were told to leave an emesis basin by the resident's bedside.

Sherrie L. Nunez, Administrator
June 10, 2013
Page 3 of 5

During the second week in July, on the morning shift, the resident was complaining of severe coughing and not being able to sleep. Two facility nurses moved a recliner in the resident's room so he would be more comfortable. They also attempted to use the dining room 's suction machine, but the machine did not have any suction and would not work. They then contacted the facility nurse practitioner who arrived around 11:00 am and ordered a blood draw and a chest x-ray. The x-ray came back with dual sided pneumonia and the facility at this point ordered two suction machines from Norco. However, the resident was observed a few weeks later without a suction machine in his room.

FINDINGS:

This complaint allegation fell within the timeframe covered by the facility's annual Recertification and State Licensure survey dated August 10, 2012, and subsequent follow-up surveys dated October 19, 2012, and December 20, 2012. During the August 10, 2012, Recertification and State Licensure survey, there were citations issued that addressed similar issues to those identified in the complaint. F309 was cited for the facility's failure to ensure residents received necessary care and services in accordance with their comprehensive assessments and plan of care.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated rooms #203 and 208 have had pest and/or ant issues for at least three years. In room #208, ants were seen running along the baseboards and two identified residents had to be treated for ant bites on several different occasions, most recently in January 2013. However, the nurses did not document the wounds as ant bites so the record will not reflect an ant problem. It looked like a rash.

The complainant stated the maintenance man found an ant nest in the crawl space and sprayed the nest for ants because the administrator would not hire an extermination company.

FINDINGS:

During the survey and complaint investigation, multiple rooms were observed for ant infestation including rooms 203 and 208. In addition, residents were interviewed including one of the residents identified in the complaint, the other identified resident's family member, the physical therapist identified in the complaint, the administrator and the maintenance supervisor.

Sherrie L. Nunez, Administrator
June 10, 2013
Page 4 of 5

Residents' records for the two identified residents were reviewed from December 2012 through April 2013 and Accounts Payable Summaries of Expenses and Invoices from two pest control companies were reviewed for November 2012 through April 2013.

During the investigation, it was determined the facility did have intermittent problems with ant infestations. Initially, the administrator arranged for routine pest control services on a monthly basis. When it was determined in January 2013 that the ant problem still existed, the pest control companies immediately increased their visits at the request of the Administrator. Ultimately, the administrator requested that the pest control company spray one-half of the building for ants every two weeks and the second half of the building the opposite two weeks. This decision was based on a report from the pest control company that the building was being sprayed too frequently, since it took two weeks for a spray to become fully effective at killing the ants. Invoices were observed from the pest control company for November 7, 2012, December 5, 2012, January 9, 2013, January 24, 2013, February 7, 2013, March 5, 2013, April 4, 2013, April 12, 2013, April 20, 2013, and April 25, 2013.

Records reviews for the two identified residents, an interview with one of the residents and an interview with the second resident's son, as well as interviews with nursing staff and the physical therapist identified in the complaint, did not indicate that the residents suffered from rashes, welts, itching or unidentified bumps between December 2012 and April 2013.

During an interview, the administrator stated that on the Sunday prior to the survey, a nurse called her at home stating ants had been seen in a resident's room and the resident had a rash that the nurse thought might be caused by ant bites. The resident went to the doctor for the rash on Monday, April 22, 2013. A report from the physician documented, "(Resident) seen today for rash... several scary (sic) hemangiomas noted plus seborrheic (sic) keratosis. A couple small pinpoint areas are noted under the left breast which are non specific and could be due to anything..." Under Assessment, the physician wrote "... no specific evidence of ant bites. No intervention at this point other that appropriate care of the room to eliminate ant problem." Note: In response to the ants found in the resident's room, the room had already been sprayed by the maintenance department on Monday, April 22, 2013, and the pest control company visited on April 25, 2013.

Based on staff, residents and family interview, as well as review of invoices submitted by the insect/pest control companies, it was determined that the facility did experienced small infestations of ants that were immediately addressed by the pest control companies. It could not be determined that resident's experienced ant bites or rashes caused by the ants.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Sherrie L. Nunez, Administrator
June 10, 2013
Page 5 of 5

ALLEGATION #4:

The complainant stated that on September 1, 2012, the wander guard alarmed in another identified resident's room, and the staff development coordinator (SDC) found the resident outside the facility. The SDC contacted the Administrator, who told the SDC to make the notes in the residents chart and that the person filling out the incident report should not use the word elopement as the incident would then have to be reported to the State (Facility Standards).

FINDINGS:

This complaint fell within the timeframe covered by of the facility's annual Recertification and State Licensure survey dated August 10, 2012, and subsequent follow-up surveys dated October 19, 2012, and December 20, 2012. During the August 10, 2012, Recertification and State Licensure survey, there were citations issued that addressed similar issues to those identified by the complainant. Please refer to the first allegation.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

As three of the complaint's allegations was substantiated, but not cited, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



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

LKK/dmj