



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 14, 2013

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

Provider #: 135076

Dear Ms. Nunez:

On **June 10, 2013**, a Facility Fire Safety and Construction survey was conducted at Trinity Mission Health & Rehab of Midland, LLC by the Bureau of Facility Standards/Department of Health & Welfare 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. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements, and a copy of the State fire safety Statement of Deficiencies form, which states the facility complies with the Fire Protection Standards of the Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. This form is for your records only and does not need to be returned.

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

Sincerely,

Mark P. Grines, Supervisor
Facility Fire Safety and Construction

MPG/Ig
Enclosures

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

Printed: 06/12/2013
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 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2013
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDL		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651	
(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)
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story fully sprinklered structure of Type V (111) construction. There is a partial basement area that houses maintenance and storage. The building is equipped with a fire alarm/smoke detection system installed in 1999. Some parts of the automatic sprinkler system were retrofitted in 1964 with subsequent additions to the system and some ordinary head replacement to quick response in 2009. An addition/remodel was completed in 2000 and a refurbish was completed in 2002. The facility was built in 1964 and is currently licensed for 112 SNF/NF beds.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on June 10, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	
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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135076	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2013
NAME OF PROVIDER OR SUPPLIER TRINITY MISSION HEALTH & REHAB OF MIDLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 46 NORTH MIDLAND BOULEVARD NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story fully sprinklered structure of Type V (111) construction. There is a partial basement area that houses maintenance and storage. The building is equipped with a fire alarm/smoke detection system installed in 1999. Some parts of the automatic sprinkler system were retrofitted in 1964 with subsequent additions to the system and some ordinary head replacement to quick response in 2009. An addition/remodel was completed in 2000 and a refurbish was completed in 2002. The facility was built in 1964 and is currently licensed for 112 SNF/NF beds.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on June 10, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE