



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 2267

September 10, 2013

Sherrie L. Nunez, Administrator
Trinity Mission Health & Rehab of Midland, LLC
46 North Midland Boulevard
Nampa, ID 83651-2145

Provider #: 135076

RE: **RECERTIFICATION AND STATE LICENSURE SURVEY REPORT COVER
LETTER**

Dear Ms. Nunez:

On **August 30, 2013**, a Recertification 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 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**

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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 **September 23, 2013**. Failure to submit an acceptable PoC by **September 23, 2013**, may result in the imposition of civil monetary penalties by **October 15, 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.

- 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 **October 4, 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 **October 4, 2013**. A change in the seriousness of the deficiencies on **October 4, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 4, 2013** includes the following:

Denial of payment for new admissions effective **November 30, 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 **March 1, 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.

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

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 **August 30, 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 **September 23, 2013**. If your request for informal dispute resolution is received after **September 23, 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: 09/09/2013
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 08/30/2013
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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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Amy Jensen, RN, Team Coordinator Sherri Case, BSW, LSW, QMRP Becky Thomas, RN</p> <p>Survey Definitions: ADL = Activities of daily living ADON = Assistant Director of Nursing cm = Centimeters DNS = Director of Nursing Serviced LN = Licensed Nurse PRN = As Needed</p>	F 000	<p>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.</p> <p style="text-align: right;">RECEIVED OCT 10 2013 FACILITY STANDARDS</p>	
F 248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on group, resident and staff interview, and record review the facility failed to provide an ongoing program of activities designed to meet the activity interests and needs for 6 of 8 random residents actively participating in the group interview meeting. This failure placed the residents at risk for boredom, and decreased enjoyment in their daily routine with potential negative impact on their emotional well-being. Findings include:</p>	F 248	<p>1. On 9/13/2013 the Activities Director completed the evening activities survey to include times and types of activities to be added to the calendar. On 9/13/2013 the current activity calendar was amended to include 3 weekly evening activities, of movie night, sing-along, bingo, card games, beading, and the Wii by the Activities Director based on the desired activities of the residents.</p> <p>2. On 9/13/2013 a survey of resident's preference of activities and the times of preferred activities was completed by the Activities Director for information to update the Activities Calendar with resident's preferences. On 9/13/2013 the Activities Director reviewed resident's activities preferences to ensure they reflected resident's current interest and concerns were addressed as noted.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X6) DATE 10/10/13
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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 248	<p>Continued From page 1</p> <p>The August 2013 "General House Calendar" documented activities ranged from 3 to 7 activities offered each day. Activities offered included council and activity committee meetings and meetings with the Administrator. Activities listed started at 9:00 or 9:30 in the morning and ended at 4:00 or 4:30 in the afternoon each day.</p> <p>On 8/27/13 at 10:45 a.m. the surveyors met with 9 residents of the facility. Eight of the residents were actively involved and responded when asked about the activities. All responded the activities were fine. The surveyor then asked what the "Awareness" and "Expressive" group involved (listed 1-2 times daily). The residents responded they did not participate in those activities as they were "not for everyone." The group was asked if there were enough activities in the evening. Six of the 8 residents responded there were not and they wanted evening activities such as games, cards, computer, dice, ceramics and beading. One resident stated the most popular activity was ceramics, but the person who was in charge of the activity had health problems and was not always able to come to the facility. The resident also stated there was an Activity Committee meeting (ACM) monthly but few residents attended the meeting. Another resident expressed there needed to be more crafts.</p> <p>After the meeting a resident (who wished to remain anonymous) stated he/she had problems with depression and needed to be kept "busy." The resident stated the evenings were difficult as there were not any scheduled activities.</p> <p>The Activities Director (AD) stated, on 8/29/13 at 9:30 a.m., there were no activities scheduled after</p>	F 248	<p>3. Beginning on 8/30/13 facility staff was re-educated by the Administrator and Interim Staff Development Coordinator on ensuring residents are provided and assisted with evening activities. On 9/4/2013 the Activities Director was re-educated by the Administrator regarding ensuring residents have scheduled activities provided to them in the evening time.</p> <p>4. Beginning the week of 9/19/2013 the Activities Director or designee will complete an audit of 5 interviewable residents weekly for 4 weeks and monthly thereafter to ensure residents interests and needs are being met with the activities that are provided. Newly admitted residents will be evaluated for activity interest by Activities Director/designee as a part of the admission process. A report will be submitted to the Quality Assurance committee monthly for 3 months and quarterly thereafter regarding outcome of audits. 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.</p> <p>Date of compliance: 9/19/2013</p>		

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F 248	<p>Continued From page 2</p> <p>the evening meal as directed by the resident council. When asked about the Awareness and Expressive activities, the AD stated those activities were for the residents with intellectual disabilities. The AD stated that in the past there were evening activities but at the beginning of the summer the council had decided not to have evening activities. The AD stated at the ACM Residents were asked if they wanted evening activities, but the question was not asked at every ACM.</p> <p>When asked about increasing the ceramics activity, the AD stated the person who was responsible for the ceramics class had health problems and could only come 1 time per month. The surveyor asked if the facility had tried to find another way to provide the ceramics class and the AD said, "No." The AD also stated the facility had not pursued the activity of beadwork as it was frustrating to some of the residents.</p> <p>The AD stated the Administrator meets with the residents in an open forum and in the past the residents have not expressed concerns regarding activities. The AD stated the Administrator had informed her the residents had expressed to the surveyors they would like evening activities. In response to the resident's concerns (about activities to the surveyors), the AD had given the residents' a form with suggested evening activities. Of the thirteen forms returned, 4 residents had marked at least three evening activities, and 7 residents had marked at least 5 activities they would enjoy. One resident stated "I can choose whatever" and one resident stated they preferred to "read in their room."</p> <p>The AD provided a revised upcoming September</p>	F 248		

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F 248	<p>Continued From page 3</p> <p>activity calendar that had an evening activity at 7:30 p.m. on Wednesdays.</p> <p>On 8/29/13, at approximately 11:30 a.m., the surveyor met with the president of the Resident Council, in his room, to discuss concerns from the meeting. Beadwork was displayed in the resident's room on his end table. The resident stated it was not done as an activity but another resident was helping him to learn to do beadwork.</p> <p>The Administrator provided summaries of the weekly meeting with the Administrator. The summaries documented no concern regarding activities on 7/11/13, 7/18/13, 7/25/13, 8/1/13 and 8/15/13, however it did not indicate if evening activities were addressed.</p> <p>On 8/30/13 at approximately 10:25 a.m. the Administrator informed the surveyors the president of the council would like to meet with them as the resident "has information that is positive toward the facility." The surveyor's went to the resident's room just as the AD was leaving the room. The resident expressed to the surveyors that at the beginning of the summer residents did not show up for evening activities. The resident stated the residents had not expressed to anyone they would like more evening activities. The resident went on to say when the surveyor asked about evening activities everyone responded. The surveyor asked why the resident was reporting this now and he stated he thought the AD was being "blamed" and would get in trouble. When asked why there would not be increased participation in evening activities in the summer he responded "people like to go outside." The surveyor asked if there were activities that could be done outside in the</p>	F 248		

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F 248	Continued From page 4 evening. The resident stated in the past they had "plastic horse shoes" and it would be a good outside evening activity.	F 248			
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 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview it was determined the facility failed to ensure care plans were periodically reviewed and revised for 4 of 12 sampled residents (#s1, 2, 4, 8). This had the potential to result in harm if residents did not receive appropriate care due to lack of direction in the care plans of Residents #4 & #8. The care plans of Residents #1 & #2 had	F 280	1. Resident #4 was re-assessed by the Social Service Director on 9/4/2013 for any psychosocial needs, and no concerns were noted. Resident #4 was re-assessed by the Interdisciplinary Team (IDT) on 9/5/2013 and no concerns were noted. On 9/5/2013 the behavior care plan was reviewed and updated by the Interdisciplinary Team (IDT). On 9/6/2013 the family was interviewed and the behavior care plan was discussed with the Social Service Director for additional input of interventions of setting boundaries and no changes were necessary. Resident #8 was re-assessed by the Social Service Director on 9/4/2013 for any psychosocial needs and no concerns were noted, Resident #8 was re-assessed by the Interdisciplinary Team on 9/5/2013 and no concerns were noted. On 9/5/2013 the behavior care plan was reviewed and updated by the Interdisciplinary Team (IDT). On 9/6/2013 the family was interviewed and the behavior care plan was discussed by the Social Service Director for additional input of interventions for setting boundaries and no changes were necessary.		

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F 280	<p>Continued From page 5</p> <p>interventions that no longer applied or goals that were not specific. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 7/3/12 and readmitted on 2/24/13 with multiple diagnoses to include, anxiety disorder, dementia with behavioral disturbance, depression, and insomnia with sleep apnea.</p> <p>Resident #4's Behavioral care plan documented, "Involve son in setting boundaries and elicit my family input for best approaches." The care plan had not been revised to include interventions with input from his family.</p> <p>2. Resident #8 was admitted to the facility on 6/12/13 with multiple diagnoses to include, depression, dementia, below the knee amputation, and memory loss.</p> <p>Resident #8's Behavioral care plan documented, "Elicit my family input for best approaches." The care plan had not been revised to include interventions with input from his family.</p> <p>On 8/29/13 at 2:00 p.m. the Administrator, DNS, and Social Services were interviewed. The surveyor asked what input have you received from the family for "best approaches and setting boundaries." The surveyor asked if this information should be on the care plan. The Administrator, DNS, and Social Services said they did not know if the family had been involved. In addition, they said the approaches and boundaries elicited from the resident's family should be on the care plan.</p> <p>3. Resident #1 was admitted to the facility on 9/1/00 and readmitted on 7/5/06 with multiple</p>	F 280	<p>Resident # 1 was re-assessed by the Social Service Director on 8/30/2013 for any psychosocial needs and no concerns were noted.</p> <p>Resident #1 was re-assessed by the Interdisciplinary Team on 9/5/2013 for urinary retention and no concerns were noted. On 9/5/2013 the care plan was reviewed and updated by the Interdisciplinary Team (IDT) for residents current urinary status</p> <p>Resident # 2 was re-assessed by the Social Service Director on 9/4/2013 for any psychosocial needs with none noted. Resident #2 was reassessed by the Interdisciplinary Team on 9/5/2013 for self induced emesis and no concerns were noted. On 9/5/2013 resident's #2 physical restraint care plan was reviewed and updated to reflect a measurable goal by the Interdisciplinary Team (IDT).</p> <p>2. On 9/18/2013 an audit of residents care plans related to behaviors, restraints, and urinary retention for the previous 30 days was completed by the Interdisciplinary Team (IDT) and goals and interventions were updated as needed.</p> <p>3. On 9/4/2013 the facility Interdisciplinary Team (IDT) was re-educated by the Administrator and Director of Nursing in regards to the evaluation and revision of resident's care plans to address their individual needs.</p>		

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F 280	Continued From page 6 diagnoses to include, multiple sclerosis, Alzheimer's disease, anxiety, and dysphagia. Resident #1's Incontinence care plan documented the resident would have, "No urine retention for the next 90 days." The care plan did not include an intervention to measure how the facility was going to ensure the resident did not have urine retention. On 8/29/13 at 2:00 p.m., the Administrator, DNS, and Social Services were interviewed. The surveyor asked the DNS how was the facility monitoring retention on Resident #1. The DNS said they are not monitoring the resident for urinary retention. The DNS said the care plan would be updated. 4. Resident #2 was admitted to the facility on 7/17/12 with diagnoses that included profound intellectual disability, seizure disorder, and dysphagia. Resident #2's Physical Restraint Care Plan, in the Problem/Need section, "Resident utilizes weighted gloves for 2 hours after meal d/t (due to) self induced vomiting..." The goal section of the care plan documented "Will have < (less than) 1 episodes of self induced emesis after meals." The care plan did not specify if there was to be less than 1 incident each day, each week, etc. On 8/29/13 at 10:45 a.m. LN #1 was asked how the facility would know if the resident had met the goal. LN #1 stated the goal should say 1 a day.	F 280	4. Beginning the week of 9/19/2013 audits will be completed of 10 comprehensive care plans by the Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to ensure residents care plans are reviewed and revised by the IDT to meet the resident's individual needs. 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 Director of Nursing is responsible for monitoring and follow-up Date of compliance: 9/19/2013		
F 314	483.25(c) TREATMENT/SVCS TO	F 314			

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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	
F 314 SS=D	<p>Continued From page 7 PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to provide the necessary nursing care and services to prevent the development of a pressure ulcer. This was true for 1 of 8 (#6) sampled residents. This created the potential for more than minimal harm when the facility failed to implement preventive measures and the resident developed a Stage II pressure ulcer to the right heel. Findings include:</p> <p>Resident #6 was admitted to the facility on 8/4/13 with multiple diagnoses including fracture - neck of femur, difficulty walking, muscle weakness, dysphagia, Alzheimer's disease and chronic kidney disease. The resident was admitted to the facility status post ORIF (Open Reduction Internal Fixation) repair to right hip fracture.</p> <p>The Initial Nursing Summary (INS) dated 8/4/13 documented Resident #6 had severe cognitive impairment and did not have any skin integrity breaks or pressure areas. A box on the INS was marked "yes" for pressure device needed in bed</p>	F 314	<p>F314</p> <ol style="list-style-type: none"> 1. Resident #6 was re-assessed by the Social Services Director on 8/30/13 and no psychosocial concerns were noted. The Nurse Manager re-assessed Resident # 6 on 9/4/2013 and no concerns were noted. On 9/5/2013 the care plan was reviewed and updated by the Director of Nursing/IDT to ensure interventions and preventative measures are in place to reflect resident's current needs. 2. On 9/6/13 an audit of residents' skin was completed to ensure there were no previously un-identified concerns by the Nurse Managers and concerns were addressed as identified. On 9/12/13 an audit of residents' Braden skin assessments was completed by the Interim Staff Development Coordinator and concerns were addressed as identified. On 9/18/2013 the Interdisciplinary Team (IDT) completed an audit of residents' care plans to ensure preventative measures reflect the residents' current status and updates were completed as needed. 3. Beginning on 8/30/2013 the facility staff was re-educated by the Administrator and Interim Staff Development Coordinator regarding the implementation of preventative measures of development of pressure ulcers including completion of assessments and updating the care plan. 		

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

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F 314	<p>Continued From page 8</p> <p>and chair, but was marked "no" for turning and repositioning.</p> <p>The initial care plan for potential skin integrity impairment for Resident #6 dated 8/5/13 documented: turn and reposition when in bed, avoid skin to skin contact, use pillows PRN, daily skin inspection during cares and to notify LN of skin integrity. The initial care plan was updated on 8/12/13 to float heels on pillow (after the pressure ulcer was found).</p> <p>Note: The care plan did not include to encourage the resident to not cross his left ankle over his right ankle (to decrease pressure on the right heel).</p> <p>A care plan for skin and wounds dated 8/12/13 included approaches for the resident to have "weekly LN skin assessment, monitor for s/sx (signs and symptoms) of infections and healing." In addition, the care plan documented to assess and record measurements weekly.</p> <p>Resident #6's problem/need care plan for skin (with a problem onset of 8/5/13), print date of 8/23/13, included in the Approach section to, "float heels while in bed." A handwritten statement, dated 8/23/13, documented, "non-compliance with leaving shoe off and elevating heels." However, there was no approach to address the noncompliance.</p> <p>Note: A treatment sheet dated 8/28/13 documented the use of a puff boot to right foot when up in WC (wheelchair) for protection. However, the care plan was not updated to include this intervention.</p> <p>A Braden Risk Assessment was performed on 8/12/13 documenting a score of 16 placing the</p>	F 314	<p>4. Beginning the week of 9/19/2013, the DON or designee will complete an audit of 10 residents weekly for 4 weeks and monthly for 2 months to ensure assessments are current and that preventative measures are care planned with interventions in place for identified risks of resident's skin. 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 is responsible for monitoring and follow-up</p> <p>Date of compliance: 9/19/2013</p>		

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F 314	<p>Continued From page 9 resident at the Mild Risk Level for pressure ulcers. Note: The Braden Risk Assessment was completed after the pressure ulcer was documented on 8/11/13.</p> <p>Nursing Notes document the following: *8/4/13-8/11/13 Resident #6 was uncooperative with cares on occasion. Note: Nursing notes contained no information regarding refusing positioning, use of pillows or daily skin checks. Additionally, there was no evaluation of the basis for the refusal, identification or evaluation of trying alternative methods. *8/11/13 at 11 PM, the nurse went in to assess Resident #6's right hip incision and, at that time, the resident complained of right heel pain. The nurse documented a 3 cm x 3 cm oval shape blister. The site is soft, tender, white in color and intact. *8/12/13 at 2:00 AM, documents heels are elevated. This is the first documentation of heels being floated. *8/12/13 at 10:45 AM, documents a fluid filled blister to right heel which is translucent in color measuring 2.0 x 1.5 cm.</p> <p>The Wound Assessment Report (WAR) documented the following: *8/11/13 Stage 2, measures length 3 cm x width 3 cm, fluid filled blister noted to medial right heel. *8/12/13 Stage 2, improved, measures length 2 cm x width 1.5 cm, applying sure prep to area. Appears to be reabsorbing on own. *8/21/13 (9 days later) Stage 2, improved, measures length 2.9 cm x width 2.3 cm, continues to be reabsorbing and is dark with a white fluid filled center.</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>The Body Audit and Hydration Report (BAHR) documented the following: *8/11/13 dark red to black blister area. *8/12/13 blood filled blister.</p> <p>Resident #6 was observed by the surveyor to be on his back in bed with heels elevated on: 8/26/13 at 2:40 PM, 8/27/13 at 9:05 AM, 9:30 AM, 9:55 AM, 1:35 AM, 8/28/13 at 10:30 AM and on 8/29/13 at 9:35 AM. On 8/27/13 at 9:30 AM and on 8/29/13 at 9:35 AM the resident was observed to have his left ankle crossed over his right ankle.</p> <p>On 8/29/13 at 9:35 AM, LN #1, was observed treating Resident #6's Stage 2 Pressure Ulcer with the ADON in attendance. The blister was intact with black areas of dried blood noted throughout the blister. The ADON was asked if the wound would be measured and she stated it was measured on 8/28/13. Note: On 8/30/13 at 8:00 AM, the facility provided additional information regarding the Stage 2 pressure ulcer, however, the WAR with measurements from 8/28/13 or any additional BAHR's were not provided.</p> <p>On 8/29/13 at 9:40 AM the ADON stated she didn't believe the pressure ulcer could have been prevented due to pain and behaviors. When asked why the wound measurements were inconsistent, she stated the measurements on 8/12/13 were not accurate as different nurses had assessed the wound. The ADON stated the wound nurse started to see the resident on 8/28/13 and will see the resident on a weekly basis. The surveyor asked for documentation of daily skin inspections and repositioning. On 8/30/13 at 8:00 AM an ADL form for the month of</p>	F 314		

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F 314	Continued From page 11 August, 2013, was provided by the facility showing the CNA's had initialed they had read and followed the daily care guide. However, no information regarding treatment for skin checks, positioning or the use of a pillow was provided.	F 314			
F 431 SS=E	The facility failed to implement the resident's heels were to be elevated and address noncompliance of interventions prior to the resident having a facility acquired pressure ulcer. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	F431 1. Resident # 9 was re-assessed by the Nurse Manager on 8/30/2013 for concerns of side effects from the Lantus Solostar 100 Units and Novolog Flex Pen 3 m/l that was not dated after opening and no concerns were noted. Resident # 15 was re-assessed by the Nurse Manger on 8/30/2013 for concerns of side effects from Lantus Solostar 100 Units and Novolog Flex Pen 3 m/l that was not dated after opening and no concerns were noted. Resident # 16 was re-assessed by the Nurse Manger on 8/30/2013 for concerns of side effects from Novolog Flex Pen 3 m/l that was not dated after opening and no concerns were noted. Resident #16 was discharged from the facility on 9/9/2013. Resident # 17 was re-assessed by the Nurse Manager on 8/30/2013 for concerns of side effects from Novolog Flex Pen 3 m/l that was not dated after opening and no concerns were noted. 2. On 8/30/2013 an audit of medication carts related to opened/unlabeled items, was completed by the Unit Managers and no other concerns were noted.		

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F 431	<p>Continued From page 12</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure time sensitive medications were properly labeled with the date they were opened. This was true for 1 of 12 sampled residents (#9) and 3 random residents (#s 15, 16, & 17). The failed practice created the potential for decreased efficacy when residents received medications with unknown open dates. Findings include:</p> <p>On 8/29/13 at 8:30 a.m., a medication cart was inspected with LN #2 and the DNS in attendance.</p> <p>Residents #s 9 and 15's Lantus Solostar 100 units/ml (milliliter) had labels documenting the medication expired after 28 days. The area to document the date the medication was opened was blank.</p> <p>Residents #s 9, 15, 16, and 17's Novolog Flex Pen 3 m/l were not labeled with the date the medications were opened.</p> <p>NOTE: Regarding Lantus insulin, the Nursing 2013 Drug Handbook, 33rd edition, states, "...Discard opened vials or cartridge system after 28 days whether refrigerated or not." The Nursing Handbook stated regarding NovoLog,</p>	F 431	<p>3. Beginning on 8/30/2013 the facility licensed nursing staff was re-educated by the Administrator and the Interim Staff Development Coordinator regarding the requirements of storing and labeling of medications.</p> <p>4. Beginning the week of 9/19/2013, the Director of Nursing or designee will complete an audit weekly for 4 weeks and monthly for 2 months to ensure medications stored in the facility are labeled and stored as required. 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 Director of Nursing is responsible for monitoring and follow-up</p> <p>Date of compliance: 9/19/2013</p>	

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F 431	Continued From page 13 "opened vials and cartridges of NovoLog are stable at room temperature for 28 days." On 8/29/13 at 9:00 a.m., the Administrator, DNS, and the Regional Vice President were informed of the issues. The DNS said, "The nurse on that medication cart is new and has only been here for a week." The Administrator and Regional Vice President said the Unit Manager had been instructed to audit the medication cart for expired meds.	F 431		

Bureau of Facility Standards

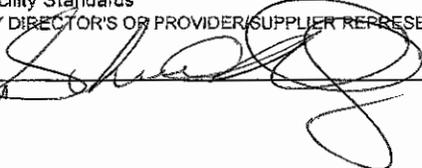
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
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NAME OF PROVIDER OR SUPPLIER TRINITY MISSION 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 of your facility. The surveyors conducting the survey were: Amy Jensen, RN, Team Coordinator Sherri Case, BSW, LSW, QMRP Becky Thomas, RN	C 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.	
C 674	02.151.01 ACTIVITIES PROGRAM 151. ACTIVITIES PROGRAM. 01. Organized Program. There shall be an organized and supervised activity program appropriate to the needs and interests of each patient/resident. The program shall be designed to include a variety of processes and services which are designed to stimulate patients/residents to greater self-sufficiency, resumption of normal activities and maintenance of an optimal level of psychosocial functioning. It shall include recreation, therapeutic, leisure and religious activities. This Rule is not met as evidenced by: Please refer to F248 as it relates to activities.	C 674	1. On 9/13/2013 the Activities Director completed the evening activities survey to include times and types of activities to be added to the calendar. On 9/13/2013 the current activity calendar was amended to include 3 weekly evening activities, of movie night, sing-along, bingo, card games, beading, and the Wii by the Activities Director based on the desired activities of the residents. 2. On 9/13/2013 a survey of resident's preference of activities and the times of preferred activities was completed by the Activities Director for information to update the Activities Calendar with resident's preferences. On 9/13/2013 the Activities Director reviewed resident's activities preferences to ensure they	
C 782	02.200.03,a,iv Reviewed and Revised iv. Reviewed and revised as needed	C 782		

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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATE FORM   0899 8C6J11 10/10/13
If continuation sheet 1 of 2

Bureau of Facility Standards

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C 782	Continued From page 1 to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F 280 as it relates to review and revision on care plans.	C 782	reflected resident's current interest and concerns were addressed as noted.	
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: Please refer to F-314 as it relates to pressure ulcers	C 789	3. Beginning on 8/30/13 facility staff was re-educated by the Administrator and Interim Staff Development Coordinator on ensuring residents are provided and assisted with evening activities. On 9/4/2013 the Activities Director was re-educated by the Administrator regarding ensuring residents have scheduled activities provided to them in the evening time. 4. Beginning the week of 9/19/2013 the Activities Director or designee will complete an audit of 5 interviewable residents weekly for 4 weeks and monthly thereafter to ensure residents interests and needs are being met with the activities that are provided. Newly admitted residents will be evaluated for activity interest by Activities Director/designee as a part of the admission process. A report will be submitted to the Quality Assurance committee monthly for 3 months and quarterly thereafter regarding outcome of audits. 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: 9/19/2013	

C 782

1. Resident #4 was re-assessed by the Social Service Director on 9/4/2013 for any psychosocial needs, and no concerns were noted.

Resident #4 was re-assessed by the Interdisciplinary Team (IDT) on 9/5/2013 and no concerns were noted. On 9/5/2013 the behavior care plan was reviewed and updated by the Interdisciplinary Team (IDT). On 9/6/2013 the family was interviewed and the behavior care plan was discussed with the Social Service Director for additional input of interventions of setting boundaries and no changes were necessary.

Resident #8 was re-assessed by the Social Service Director on 9/4/2013 for any psychosocial needs and no concerns were noted,

Resident #8 was re-assessed by the Interdisciplinary Team on 9/5/2013 and no concerns were noted. On 9/5/2013 the behavior care plan was reviewed and updated by the Interdisciplinary Team (IDT). On 9/6/2013 the family was interviewed and the behavior care plan was discussed by the Social Service Director for additional input of interventions for setting boundaries and no changes were necessary.

Resident # 1 was re-assessed by the Social Service Director on 8/30/2013 for any psychosocial needs and no concerns were noted.

Resident #1 was re-assessed by the Interdisciplinary Team on 9/5/2013 for urinary retention and no concerns were noted. On 9/5/2013 the care plan was reviewed and updated by the Interdisciplinary Team (IDT) for residents current urinary status

Resident # 2 was re-assessed by the Social Service Director on 9/4/2013 for any psychosocial needs with none noted.

Resident #2 was reassessed by the Interdisciplinary Team on 9/5/2013 for self induced emesis and no concerns were noted. On 9/5/2013 resident's #2 physical restraint care plan was reviewed and updated to reflect a measurable goal by the Interdisciplinary Team (IDT).

2. On 9/18/2013 an audit of residents care plans related to behaviors, restraints, and urinary retention for the previous 30 days was completed by the Interdisciplinary Team (IDT) and goals and interventions were updated as needed.

3. On 9/4/2013 the facility Interdisciplinary Team (IDT) was re-educated by the Administrator and Director of Nursing in regards to the evaluation and revision of resident's care plans to address their individual needs.

4. Beginning the week of 9/19/2013 audits will be completed of 10 comprehensive care plans by the Director of Nursing or designee weekly for 4 weeks and monthly for 2 months to ensure residents care plans are reviewed and revised by the IDT to meet the resident's individual needs. 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 Director of Nursing is responsible for monitoring and follow-up

Date of compliance: 9/19/2013

C 789

1. Resident #6 was re-assessed by the Social Services Director on 8/30/13 and no psychosocial concerns were noted. The Nurse Manager re-assessed Resident # 6 on 9/4/2013 and no concerns were noted. On 9/5/2013 the care plan was reviewed and updated by the Director of Nursing/IDT to ensure interventions and preventative measures are in place to reflect resident's current needs.

2. On 9/6/13 an audit of residents' skin was completed to ensure there were no previously un-identified concerns by the Nurse Managers and concerns were addressed as identified.

On 9/12/13 an audit of residents' Braden skin assessments was completed by the Interim Staff Development Coordinator and concerns were addressed as identified.

On 9/18/2013 the Interdisciplinary Team (IDT) completed an audit of residents' care plans to ensure preventative measures reflect the residents' current status and updates were completed as needed.

3. Beginning on 8/30/2013 the facility staff was re-educated by the Administrator and Interim Staff Development Coordinator regarding the implementation of preventative measures of development of pressure ulcers including completion of assessments and updating the care plan.

4. Beginning the week of 9/19/2013, the DON or designee will complete an audit of 10 residents weekly for 4 weeks and monthly for 2 months to ensure assessments are current and that preventative measures are care planned with interventions in place for identified risks of resident's skin. 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 is responsible for monitoring and follow-up

Date of compliance: 9/19/2013