



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

FILE COPY

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: lsb@dhw.idaho.gov

CORRECTED COPY OF SURVEY COVER LETTER: AUGUST 21, 2015

August 14, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **July 31, 2015**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **June 10, 2015**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F332 -- S/S: D -- 483.25(m)(1) -- Free of Medication Error Rates of 5% or More

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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.

Darrin Radeke, Administrator
August 14, 2015
Page 2 of 3

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your copy of the Form CMS-2567B, Post-Certification Revisit Report listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 27, 2015**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

As noted in the Bureau of Facility Standards' letters of **May 5, 2015**, and **May 27, 2015**, following the surveys of **April 10, 2015**, and **May 20, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **October 10, 2015**, if substantial compliance is not achieved by that time. The findings of non-compliance on **July 31, 2015**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **May 7, 2015**.

Darrin Radeke, Administrator
August 14, 2015
Page 3 of 3

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

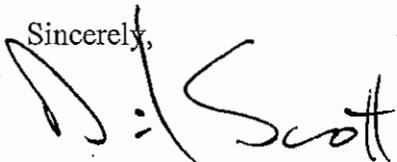
- BFS Letters (06/30/11)

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

This request must be received by **August 27, 2015**. If your request for informal dispute resolution is received after **August 27, 2015**, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/j
Enclosures

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

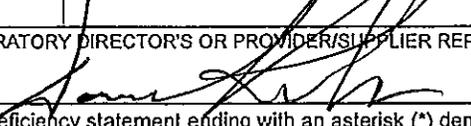
PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/31/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{F 000}	INITIAL COMMENTS The following deficiencies were cited during the onsite follow-up and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN The survey team entered the facility on July 29, 2015 and exited on July 31, 2015. 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate of less than 5 percent. This was true for 7 of 26 medications (26.92%) which affected 1 of 5 residents (#28) reviewed for medication administration practices. This failure created the potential for harm if residents received less than optimum benefit from the prescribed medications. Findings included: 1. Resident #28's Physician's Medication Report for July 2015 included orders for Multivitamin & Mineral Liquid, 30 cc via G-tube one time daily; Levothyroxine, 88 mcg via G-tube daily on an empty stomach with water; Nexium Unit-Dose 40 mg orally one time daily at least one hour before	{F 000}	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.	
{F 332} SS=D		{F 332}	F332 1. The citation was corrected for: Res #28 The Oxybutynin ER was changed to the Oxybutynin liquid on 7/30/15. No adverse reaction to the medication was noted and also none was noted by the consulting Pharmacist. All nurses who crushed and administered the Oxybutynin ER have been educated per facility policy. On 8/7/15 all nurses received training on the proper administration of medications.	9/11/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 8/25/14
---	------------------------	----------------------

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.

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

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/31/2015
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
(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 332}	<p>Continued From page 1</p> <p>meal; Oxybutynin Chloride 5 mg one tablet via G-tube daily; Wellbutrin 75 mg tablets two tablets daily at 6:00 AM and 12:00 PM; and Benztropine Mesylate 1 mg, one tablet via G-tube twice daily.</p> <p>On 7/30/15 at 9:00 AM, LN #1 was observed to dispense and crush the following medications:</p> <ul style="list-style-type: none"> - Childrens chewable multivitamin; - Levothyroxine 88 mcg tablet; - Oxybutynin ER 5 mg tablet; - Benztropine 1 mg tablet; and - Wellbutrin HCl (Immediate Release) 75 mg tablets (150 mg). <p>On 7/30/15 the following was observed:</p> <ul style="list-style-type: none"> - 9:05 AM - LN #1 was stopped prior to administering the Oxybutynin ER. When asked if the Oxybutynin ER could be crushed the nurse stated, "Yes." The LN and surveyor reviewed the medication card label which documented, "Not to be chewed or crushed." - 9:15 AM - the resident's prescribed doses of Levothyroxine and Wellbutrin were administered, both of which were ordered for a 6:00 a.m. administration; Nexium, which was ordered for administration at least one hour before meal; and Oxybutynin and Benztropine, both of which were scheduled for administration at 7:00 AM. - 9:20 AM - Fiber Source enteral tube feeding was started. - 11:36 AM, Wellbutrin HCl (Immediate Release) 150 mg was administered. The medication label on the Wellbutrin documented the medication was to be administered at 6:00 AM and 12:00 PM, or 6 hours apart. The resident received the second dose approximately 2 hours and 15 minutes after the first dose. <p>Note: The Fiber Source tube feeding was started</p>	{F 332}	<p>The Nexium and Levothyroxine that were to have been administered on an empty stomach have been effectively changed. Investigation showed no other medication for any other resident was given late or that should have been given on an empty stomach since that date. On 8/7/15 all nurses received training on the proper administration of medications.</p> <p>The Wellbutrin medication that had doses that were administered too close to each other have not caused adverse reaction in the resident and the nurse who administered the medications too close together has been educated and disciplined as per facility policy. All medications for the resident that state they are to be given PO have been changed to read per G-tube. On 8/7/15 all nurses received training on the proper administration of medications.</p> <p>The multivitamin that was administered without minerals and not in liquid form have not caused adverse reaction in the resident and the nurse who administered the vitamin has been educated and disciplined as per facility policy. On 8/7/15 all nurses received</p>		

4dy

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

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/31/2015
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
(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 332}	Continued From page 2 immediately after the Levothyroxine and Nexium were administered, therefore those medications were not administered on an empty stomach, per physician order. On 7/31/15 at 10:30 AM, the Administrator, System Consultant, and the DNS were informed of the identified medication errors.	{F 332}	training on the proper administration of medications and vitamin vs. vitamins with minerals. 2. Others will be identified who may be affected by the deficient practice through identifying those who have medications that require crushing and ensuring through medication pass audits that all nurses are giving medications appropriately. The facility brought the Regional Auditor for Omnicare Pharmacy who did an audit of medication passes and trained nurse management on proper medication pass for nursing homes. Nurse management will ensure that 100% of the nurses have been audited a minimum of 2 medication passes with less than 5% discrepancy, by September 11, 2015 3. The systematic change to ensure deficient practice does not recur by continual, scheduled medication pass audits to be done for each nurse tracked on the medication pass audit tracking form.	

4 dy

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

PRINTED: 08/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/31/2015
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318		
(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 332}		{F 332}	4. 14 medication pass audits will be completed weekly X 2 weeks, then monthly X 2 months, and quarterly X2, then annually. The DNS or Nurse Manager will be responsible for ensuring audits are completed and the information is brought to the quality assurance committee for review.		

dy



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. - Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 21, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **July 31, 2015**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint was investigated in conjunction with the facility's on-site revisit to the Recertification and State Licensure survey.

The following observations were completed:

Staff were observed for appropriate interactions with residents.

The following documents were reviewed:

- The entire medical record of the identified resident;
- Five other residents' records were reviewed for Quality of Care concerns;
- The facility's Grievance file from June 10 to July 29, 2015;
- Resident Council minutes from June 10 to July 29, 2015;
- The facility's Incident and Accident reports from June 10 to July 29, 2015;
- The facility's Allegation of Abuse reports from June 10 to July 29, 2015; and,
- The facility's video recording of an alleged abuse event regarding the identified resident.

The following interviews were completed:

- Several residents were interviewed regarding Quality of Care concerns;

Darrin Radeke, Administrator

August 21, 2015

Page 2

- The Director of Nursing and the Administrator were interviewed regarding abuse investigations; and,
- Eleven CNAs and two Nursing Assistants were interviewed regarding abuse.

The complaint allegations, findings and conclusions are as follows:

Complaint #7115

ALLEGATION #1:

The complainant stated an identified resident was abused and the facility did not follow procedures to ensure the safety of residents from the alleged abuser.

FINDINGS #1:

During the survey, a recent alleged abuse investigation involving the identified resident was reviewed. The Administrator and DoN, interviewed regarding the investigation, said they could not substantiate abuse due to lack of evidence and video surveillance of the alleged incident.

Interviews with staff members regarding the incident had differing opinions of what they saw and heard regarding the alleged event.

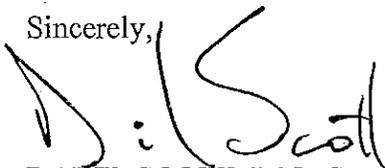
Based on the record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Eker Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

FILE COPY

August 7, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **April 10, 2015**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #6673

ALLEGATION #1:

The complainant stated the facility smelled like unwashed bodies.

FINDINGS #1:

The allegation was investigated in conjunction with the facility's licensing and recertification survey from April 6, 2015 through April 10, 2015. Daily observations were completed at varying times across shifts; interviews were conducted with two shower aides, individual residents, the resident group association and family members.

Resident Council minutes and resident grievances for the past three months were reviewed. Shower schedules for ten sample residents were reviewed.

During observations, throughout the five days, transient odors were present; however, the odors were for a short period and were not identified as body odor.

Darrin Radeke, Administrator

August 7, 2015

Page 2

Four individual residents interviewed and two family members stated the facility was cleaned regularly and there was not a problem with odors in the facility.

Six residents participating in a meeting with the surveyors stated odors in the facility were not a problem. Five of the residents stated they received showers 2-3 times a week, which was sufficient. One resident stated she would like showers every day, but was not currently receiving a daily shower.

The two bath aides stated if a resident missed a shower then it would be rescheduled for the following day. Both aides stated at the current time there were no residents receiving a daily shower, but they had residents in the past who were showered on a daily basis.

Ten sample residents' shower records documented they received two to three showers a week unless the shower was refused.

Minutes from the Resident Council Meeting and grievances reviewed did not document concerns with odors in the facility.

Based on observations, residents interviewed and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated therapy is "atrocious." No further details were provided.

FINDINGS #2:

Interviews were conducted with the Supervisor of therapy services, the Restorative Nursing Assistant and two residents receiving range of motion services.

Therapy care plans and notes were reviewed for five sample residents.

Observations for the use of adaptive equipment were completed.

The Supervisor of Therapy stated the facility had process for referring a resident to therapy. Typically, nursing assistants would express concerns regarding range of motion to the Supervisor of Therapy. The Supervisor would meet with the nurse for the identified resident and they would develop a plan for the type of therapy required for the resident. The Supervisor of Therapy stated she also got referrals from the resident's physician. If a resident were referred, the appropriate discipline would evaluate whether therapy services were necessary. If a resident experienced a decline in their physical abilities, the therapist would write an appropriate restorative nursing program to complement and enhance the resident's current therapy.

The Restorative Nursing Assistant stated for one of the sample residents he was working on range of motion for his lower extremities. The Restorative Nursing Assistant stated for another identified resident he had been working on walking, but the resident had consistently refused and the therapy was eventually discontinued. The resident's medical records confirmed the information the Restorative Nursing Assistant relayed to the surveyor.

A resident receiving range of motion for his lower extremities stated the Restorative Nursing Assistant worked with him on moving his legs. Another stated she did not receive range of motion services "anymore."

Physical Therapy notes reviewed from April 14, 2014 through July 22, 2014, documented the resident had been participatory in therapy; however, the resident was discharged from Physical Therapy on July 22, 2015, related to their medical condition.

Occupational Therapy notes reviewed from April 11, 2015 through August 23, 2014, documented the resident had been participatory in therapy; however, on August 23, 2014, the resident was discharged from Occupational Therapy related to the same medical condition.

Five residents and two family members interviewed did not verbalize concerns related to the therapy programs provided by the facility.

Six residents who participated in the group interview did not verbalize complaints and/or concerns related to the therapy programs provided by the facility.

Based on observations, residents interviewed and staff interviewed, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the identified resident developed a pressure ulcer, with MRSA, on his/her buttocks.

FINDINGS #3:

During the survey, the medical records of four residents identified by the facility as high risk for pressure and/or having pressure ulcers were reviewed.

The facility's Policy and Procedures for Pressure Ulcers was reviewed.

Weekly skin assessment forms, care plans, physician orders and wound treatments were reviewed.

The Director of Nursing was interviewed.

This allegation was substantiated and cited at F314.

CONCLUSIONS:

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

ALLEGATION #4:

The complainant reported staff had a bad attitude and were sarcastic in their tone of voice.

FINDINGS #4:

There was no quantifiable or measureable way to determine staff attitude. Additionally, there is no specific federal regulatory requirement related to customer service and/or best practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated there were no signs posted on resident doors to check with the nurse related to infections before going into the resident rooms.

The complainant stated staff did not wash their hands before or after residents were changed and/or before or after staff took their gloves off.

FINDINGS #5:

The Center for Disease Control (CDC) recommends that Standard Precautions and Contact Precautions be used when working with a resident who has MRSA in a wound. The CDC does not require Long Term Care facilities to place signage on a resident's door directing visitors to contact the nurse prior to entering the resident's room for a resident with a covered wound containing a MRSA infection.

The federal requirement at F441, Infection Control, requires the facility to establish an Infection Control Program that reflects the current CDC guidelines and does not require the facility to place a sign on the resident's door to check with the nurse prior to entering the resident's room.

Federal regulation F281, standards of practice, does not require the facility to place signage on a resident's door, under the reported circumstance.

During the survey process, multiple proper hand washing observations, across various shifts were made.

The facility's infection control program reviewed by the survey team did not identify concerns related to

Darrin Radeke, Administrator

August 7, 2015

Page 5

improper hand washing.

Staff in-services on hand washing reviewed documented in-services were done at least quarterly and more often if necessary.

The Infection Control nurse stated she "spot checks" staff providing care to ensure proper hand washing is being done and provides further education and demonstration when areas of concern arises.

Based on observations, policy review, staff interview and review of regulatory and CDC requirements, it was determined the above allegations could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T—Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 21, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **April 10, 2015**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint allegations, findings and conclusions are as follows:

Review of the facility's admit pack, which included Residents Rights documented the facility would provide necessary communication services to the residents, to include a sign language interpreter.

Observations of residents with special communications needs were made over a four day period.

The records of residents with special communications needs were reviewed.

The Director of Nurses was interviewed.

Complaint #6959

ALLEGATION #1:

The complainant stated the facility failed to accommodate resident's communication needs.

Darrin Radeke, Administrator
August 21, 2015
Page 2

FINDINGS #1:

The allegation was substantiated and cited at F154.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the facility transferred residents to the hospital without notifying the family.

FINDINGS #2:

The complainant stated he/she filed a formal complaint with facility related to the identified concern and the Director of Nursing acknowledged the incident and implemented the necessary corrective action.

Based on the information provided by the complainant and the facility's response to the concern, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated a resident had been distraught when hospitalized as translation services were not provided there.

FINDINGS #3:

The Long Term Care Survey team does not survey the care and services provided to patients and/or residents in the hospital setting; therefore, the survey team could not investigate the identified concern.

CONCLUSIONS:

Unsubstantiated. Long Term survey team does not investigate the care and services to residents in a hospital.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as

Darrin Radeke, Administrator

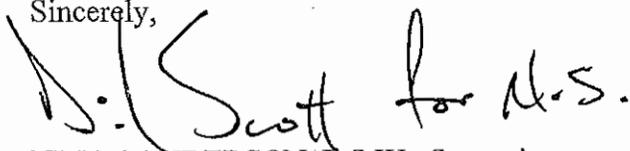
August 21, 2015

Page 3

it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott for N.S.". The signature is written in a cursive style with a large initial "D" and "S".

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj