



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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February 17, 2018

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

Provider #: 135081

Dear Mr. Radeke:

On **February 7, 2018**, we conducted an on-site revisit and a complaint investigation 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 **December 09, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

F0000 -- S/S: -- -- Initial Comments

F0353 -- S/S: D -- 483.35(a)(1)-(4) -- Sufficient 24-Hr Nursing Staff Per Care Plans

F0520 -- S/S: E -- 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) -- Qaa

Committee-Members/meet Quarterly/plans

F600 - S/S:D - 483.12 Freedom from Abuse, Neglect, and Exploitation

F607- S/S:E- 483.12(b) Freedom from Abuse, Neglect, and Exploitation

F609 - S/S:E - 483.12(c) Freedom from Abuse, Neglect, and Exploitation

F610 - S/S:E - 483.12(c)(2-4) Freedom from Abuse, Neglect, and Exploitation

F658 - S/S:D - 483.21(b)(3)(i) Comprehensive Care Plans

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 27, 2018.**

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' letter of **November 17, 2017**, following the survey of **October 27, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a Civil Monetary Penalty, Denial of Payment for New Admissions effective **January 27, 2018** and termination of the provider agreement on **April 27, 2018**, 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.

Darrin Radeke, Administrator

February 17, 2018

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If you believe the deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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)

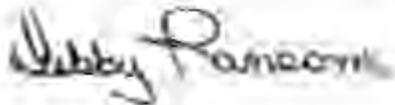
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 27, 2018**. If your request for informal dispute resolution is received after **February 27, 2018**, 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 please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/dr

Enclosures

Darrin Radeke, Administrator

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

PRINTED: 03/26/2018
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 02/07/2018
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NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318
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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 A revisit survey in conjunction with complaint investigation survey was conducted at the facility on February 5, 2018 to February 7, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD	{F 000}		
{F 353} SS=D	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	{F 353}		3/1/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/27/2018
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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 353}	Continued From page 1 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. This failed practice had a direct negative impact on the level of supervision and/or services provided to 1 of 5 sampled residents (#17) and 3 random residents (#s 25-27) and placed the health and safety of all 49 residents in the facility at risk of harm should the staffing shortage result in the failure to deliver care as physician ordered, as care planned, or otherwise needed. Findings include: The facility's One-to-One Staffing policy job description documented, "One staff member will	{F 353}	The facility will ensure that there is an adequate level of staffing to provide needed care for the residents of the facility. Residents #17, 25, 26, and 27 have been evaluated by the physician and the IDT and it has been determined that they were not injured by the deficient practice. An inservice was given on 2/9/18 for all staff to review the 1:1 Staffing Policy, the 15 Minute Check Policy, and the Call in Policy. 1:1 staffing status for each resident is determined quarterly with Care Planning and prn by the interdisciplinary team. The facility has implemented a new 15		

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{F 353}	<p>Continued From page 2</p> <p>be assigned to be with a 1:1 resident during designated times." Requirements for staff assigned as a 1:1 duties are as follows:</p> <ul style="list-style-type: none"> * "The One-To-One Resident will be within arm's reach radius at all times. There is no exception to this rule." * "Do not leave the 1:1 resident for any reason." * "When the 1:1 resident is walking or sitting near another resident make sure you are in between the residents at all times." <p>On 2/5/18 at 11:30 PM, CNA #13 stated she was assigned as a 1:1 for Resident #17 on 2/1/18 at 10:00 PM. CNA #14 was sent home and CNA #13 was reassigned to work as the floor CNA on the South Hall. CNA #13 stated Resident #17 was changed to be a 15-minute check for the rest of the 10:00 PM to 6:00 AM shift.</p> <p>The North Daily Assignment Sheet, dated 2/1/18, documented CNA #13 was assigned as a 1:1 for Resident #17. The South Daily Assignment Sheet, dated 2/1/18, documented CNA #13 signed in as the floor CNA.</p> <p>On 2/6/18 at 9:15 AM, the DNS provided a list of Residents with 1:1's as follows:</p> <ul style="list-style-type: none"> * Resident #18 - 16 hours a day started 3/17/17. * Resident #5 - 24 hours a day/7 days a week, when staff is available - 15 min checks when no 1:1, started 1/23/18. * Resident #17 - 24 hours a day/7 days a week, started 12/27/17. * Resident #25 up to 24 hours with trial 	{F 353}	<p>minute Checking Policy to ensure residents are monitored appropriately and a Call in Policy for ensuring coverage of shifts. An inservice was given on 2/9/18 for all staff to review the 1:1 Staffing Policy, the 15 Minute Check Policy, and the Call in Policy.</p> <p>A Shift Coverage Audit has been implemented and is completed by the DNS or Administrator to monitor appropriate coverage of shifts. The audit will be reviewed each weekday for previous days, current day, and future days. The IDT will proactively assist where there is a shortfall in staffing to ensure all required spots are filled. The Shift Coverage Audit will be the responsibility of the DNS and will be brought to the QAPI meeting by the DNS for review and to ensure compliance. This review of the audit and the associated teaching will occur monthly X 3 and quarterly X 2.</p>		

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{F 353}	<p>Continued From page 3</p> <p>reductions as appropriate started 11/8/17.</p> <p>* Resident #7 - 24 hours a day/7 days a week started 10/25/17.</p> <p>* Resident #10 - trial 1:1 to identify if having the 1:1 decreases or increases intrusiveness. Determined by nursing started on 2/1/18.</p> <p>On 2/6/18 at 9:15 AM, the DNS stated the facility was unable to replace the CNA that went home sick, which made the night shift for 2/1/18 short staffed.</p> <p>On 2/7/18 at 2:30 PM, the Administrator stated Resident #17 needed 1:1 supervision 24/7.</p> <p>The facility's Daily Assignment Sheet for South Hall, dated 2/1/18 through 2/5/18, documented Resident #25 as a 1:1 for all three shifts, but was left blank on the following shifts:</p> <ul style="list-style-type: none"> * 2/1/18 evening shift and night shift. * 2/2/18 day shift and evening shift. * 2/3/18 evening shift. * 2/4/18 day shift, evening shift, and night shift. * 2/5/18 evening shift. <p>The facility's Daily Assignment Sheet for North Hall, dated 2/4/18, documented Resident #10 was assigned a 1:1 for day shift and evening shift, but was left blank.</p> <p>On 2/6/18 at 10:30 AM, the DNS stated the facility was short staffed on the days that were left blank for the assigned 1:1 staff members for Residents #10 and #25.</p> <p>The facility's Entry Hall Monitor "Door Monitor" job description documented, "Entry Hall Monitors</p>	{F 353}			

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{F 353}	<p>Continued From page 4</p> <p>are to be at their station at all times. To ensure residents do not leave the building unattended and are signed out with the appropriate nurse."</p> <p>On 2/7/18 at 3:00 PM, the facility was unable to provide a policy for the 15-minute checks during survey.</p> <p>On 2/8/18, the facility faxed the facility's 15-Minute Checks policy, revised 2/8/18, documented, "Requirements for staff assigned to do 15 minute checks as follows:</p> <ul style="list-style-type: none"> * "The staff will visualize the patient on 15-minute checks at a minimum of every 15-minutes. There is no exception to this rule." * "Staff will document the patient's behavior and whereabouts of the patient every 15-minutes on the 15-minute check form." * "Documentation is to be done in real time on the 15-minute check sheets, do not pre-enter the times prior to visualizing the patient." <p>On 2/7/18 at 1:15 PM, CNA #12, the door monitor, was observed documenting on a 15-minute check report for Residents #26 and #27. CNA #12 stated she saw a staff member wheel Resident #26 in her room. CNA #12 stated she did not observe Resident #26 in her room. CNA #12 documented Resident #27 was in the dining room. CNA #12 stated she saw a staff member wheel him to the dining room, so she signed it as "DR", but did not observe Resident #27 in the dining room.</p> <p>On 2/7/18 at 1:30 PM, the DNS stated the door</p>	{F 353}			

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{F 353}	Continued From page 5 monitor should not have been assigned to the 15-minute checks, because the door monitor was unable to leave the area. The DNS stated another staff member needed to be assigned to the 15-minute checks.	{F 353}			
{F 520} SS=E	<p>QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>(h) Disclosure of information. A State or the Secretary may not require disclosure of the</p>	{F 520}		3/1/18	

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{F 520}	<p>Continued From page 6</p> <p>records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and evidence of non-compliance in quality of care and nursing services, it was determined the facility failed to maintain a quality assessment and assurance committee (QAA) that identified concerns or developed and implemented action plans in the areas of abuse and neglect, supervision, and sufficient numbers of nursing staff. This was true for 3 of 11 sampled residents (#s 15, 18, and 19) and 5 random residents (#s 10 and 21-24) due to the facility's failure. Findings include:</p> <p>During the follow-up survey ending on 2/7/18, the facility was cited at:</p> <p>* F353. The facility had frequent vacancies in the nursing staff assignment roster, which resulted in insufficient numbers of nursing staff to meet resident care planned needs.</p> <p>During the complaint survey ending on 2/7/18, the facility was cited at:</p> <p>* F600 as it relates to the failure of the facility to follow its policy to ensure injuries of unknown source were investigated as potential allegation of abuse or neglect.</p>	{F 520}	<p>The facility will ensure that it's quality assurance program is monitoring and improving needed elements to provide needed care for it's residents.</p> <p>For residents #s 15, 18 19, 10, and 21-24, physician review of their individual conditions was made to ensure the deficient practice had not provided harm to those residents. The facility also interviewed all residents who are able to give clear answers to questions and front line staff asking, "In the last 3 month have you seen anyone being mistreated or being treated badly?" This interview showed that there was no mistreatment that had not been properly investigated and dealt with during this time period.</p> <p>F353- Audit of Assignment sheets will occur each weekday to ensure coverage of shifts.</p> <p>F600- A follow-up check sheet will be done and all skin and fall issues will be reviewed for completeness by the Corporate Clinical Nurse Manager. She will provide added council on whether the issue is reportable or not.</p> <p>F607- A follow-up check sheet will be</p>		

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{F 520}	Continued From page 7 * F607 as it relates to the facility's failure to operationalize its policy to ensure potential allegations of abuse were investigated and reported. * F609 as it relates to the facility's failure to follow its policy to ensure allegations of abuse were reported to State Agency within 2 hours, or within 24 hours. * F610 as it relates to the facility's failure to thoroughly investigate potential abuse allegations. On 2/7/18 at 2:30 PM, the Administrator stated the QAA committee were reviewing the concerns identified from the 10/27/17 recertification survey in their meetings. The Administrator stated the facility had not identified concerns related incomplete investigation to rule out injuries of unknown sources as potential incidents of abuse and /or neglect, reporting injuries of unknown sources, and operationalize its abuse policy for review in the QAA committee, or developed or implemented action plans or monitoring for these issues.	{F 520}	done and all skin and fall issues will be reviewed for completeness by the Corporate Clinical Nurse Manager. She will provide added council on whether the issue is reportable or not. F609- A follow-up check sheet will be done and all skin and fall issues will be reviewed for completeness by the Corporate Clinical Nurse Manager. She will provide added council on whether the issue is reportable or not. F610- A follow-up check sheet will be done and all skin and fall issues will be reviewed for completeness by the Corporate Clinical Nurse Manager. She will provide added council on whether the issue is reportable or not. All audits and Corporate Clinical Nurse Manager report will be brought to the QAPI meetings to be reviewed and discuss whether acceptable thresholds are met and methods to improve performance. Corporate Owner, Director of Compliance and/or Vice President of Clinical Operations will review compliance weekly X3 and monthly X 2.		



IDAHO DEPARTMENT OF
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BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 10, 2019

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

Provider #: 135081

Dear Mr. Radeke:

On **February 5, 2018** through **February 7, 2018**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007687

ALLEGATION #1: The facility was not notifying the physician of residents changes of conditions.

FINDINGS #1:

Twenty residents were observed for Quality of Care issues, medication management, neglect, injuries of unknown origin, and nursing services concerns. Quality of Care practices were observed, including staff interaction with residents and medication distribution.

The clinical records of twenty residents were reviewed for Quality of Care issues and medication management. The facility's Grievance file was reviewed, as well as its medication review and social service concerns.

Ten residents, fourteen CNAs, and four nurses were interviewed regarding various Quality of Care issues, neglect, medication management issues, nursing services. The Director of Nursing and the Administrator were interviewed regarding various issues.

The clinical records of four resident were reviewed and documented they received their medications as ordered and when they did not the physician was notified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The nurses did not document the reason and effectiveness of medications or the reason for the need of the medication.

FINDINGS #2:

The clinical records documented three residents received their psychotropic medications based on assessments, monitoring for effectiveness, and clinical evaluations. The clinical record documented residents' medication treatment and other treatments were consistently monitored and adjusted for effectiveness.

Several nurses and the Director of Nursing said the residents had mental illnesses that required the medications as part of treatment.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Nurses were hiding psychotropic medications in residents food.

FINDINGS #3:

An identified resident was not in the facility.

Several nurses and the Director of Nursing said residents medications were not hidden in their food.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

A resident's wound treatment was not provided per physicians orders.

FINDINGS #4:

Based on record review and interviews with staff and residents, it was determined the facility provided the necessary care and services for residents' treatment management.

A resident's record documented she was to receive treatments and skin to the coccyx which the Medication Administration Record documented she was administered consistently.

Based on the results of the investigation, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents' injuries of unknown origin were not investigated, reported, as potential allegations of abuse.

FINDINGS #5:

Based on record review and interviews with staff and residents, it was determined the facility did not provide necessary care and services for residents' treatment management.

Eight residents records documented they received multiple injuries of unknown origin. The residents' records did not include witness statements, staff interviews, or resident interviews to determine the origin of the bruises, or a complete investigation to rule out potential abuse or neglect.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F600 as it relates to the failure of the facility to ensure injuries of unknown origin were

investigated as potential abuse and neglect. A deficiency was cited at F607 as it relates to the failure of the facility to ensure its abuse policy was implemented. A deficiency was cited at F609 as it relates to the failure of the facility to ensure residents potential abuse and neglect situations were reported. A deficiency was cited at F610 as it relates to the failure of the facility to ensure residents potential abuse and neglect situations were investigated.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

A resident received inappropriate supervision.

FINDINGS #6:

The clinical record of a resident was reviewed and documented she had interventions in place to prevent falls such as anti-tip bars on her wheelchair.

Several nurses, a maintenance director, and the Director of Nursing said the resident utilized a spare chair while her wheelchair was repaired with the anti-tip bars.

A resident stated she did not have a concern with falls or the interventions the facility provided for her on terms of fall prevention.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The facility did not have a system in place to destroy discontinued narcotic medications.

FINDINGS #7:

Based on record review and interviews with staff and residents, it was determined the facility did not discontinue and not destroyed narcotic medications in a timely manner.

A resident's record documented she received multiple doses of a narcotic medications after the medication was discontinued.

Darrin Radeke, Administrator
January 10, 2019
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Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F658 as it relates to the failure of the facility to ensure narcotic medications were destroyed timely.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj