



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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
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July 27, 2018

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

Provider #: 135081

Dear Mr. Radeke:

On **July 13, 2018**, a survey was conducted at Mini-Cassia Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual 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. 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.

After each deficiency has been answered and dated, the administrator should sign the Form

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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 Plan of Correction (PoC) for the deficiencies must be submitted by **August 6, 2018**. Failure to submit an acceptable PoC by **August 6, 2018**, may result in the imposition of civil monetary penalties by **August 29, 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; and
- 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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

Civil money penalty,

Denial of payment for new admissions effective October 13, 2018

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 13, 2019**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these 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. 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.

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 **August 6, 2018**. If your request for informal dispute resolution is received after **August 6, 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,

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comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208)
334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, flowing style.

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

dr/lj
Enclosures

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

PRINTED: 09/04/2018
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 C 07/13/2018
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 complaint survey of the facility. The survey team entered the facility on July 11, 2018 and exited the facility on July 13, 2018. The surveyors were: Edith Cecil, RN Suzy Devereaux, BSN, RN Abbreviations: cm = Centimeter CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MDS = Minimum Data Set RN = Registered Nurse % = percent	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		8/3/18	

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

TITLE

(X6) DATE

Electronically Signed

08/03/2018

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 656	<p>Continued From page 1</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure comprehensive resident centered care plans included the goals and interventions for the care and treatment of a pressure ulcer. This was true for 1 of 3 resident (#1) reviewed for pressure ulcers. This deficient practice placed the resident at risk for the development and/or worsening of pressure ulcers. Findings include:</p> <p>Resident #1 was admitted to the facility on</p>	F 656	<p>Resident #1's care plan was updated on 7/12/18 to address the left heel focus and interventions. Resident is currently noncompliant with many of the care interventions that have been put in place. The new wound nurse will submit a comprehensive skin care plan and update that will be reviewed by the skin committee a minimum of each month on all wounds in the facility to ensure compliance and accuracy.</p>		

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

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F 656	<p>Continued From page 2</p> <p>1/26/17 with multiple diagnoses which included diabetes mellitus, stroke, and major depressive disorder recurrent severe psychotic symptoms. A hospital discharge summary, with a print date of 1/13/18, documented she was admitted to the ER (emergency room) from the facility on 1/10/18 following a fall with a left hip fracture. The summary stated Resident #1 was discharged from the hospital back to the facility on 1/13/18 following surgical repair of her left hip fracture.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 1/31/18, documented Resident #1 was moderately cognitively impaired and required extensive assistance from 2 plus staff for bed mobility and transfers.</p> <p>A nursing progress note, dated 1/19/18 at 11:35 AM, documented a dark purple fluid filled area on the back of Resident #1's left heel that measured 4.0 x 6.0 cm and was unstageable. A nursing progress note, on the same date at 11:45 AM, documented Podus boots (pressure relief) were placed on Resident #1's heels and the wound nurse was contacted regarding the pressure ulcer.</p> <p>On 1/19/18 a problem area was added Resident #1's Skin at Risk Care Plan, instructing staff to monitor the unstageable wound on her left heel which was present on her return from the hospital. There were no goals for the healing of the pressure ulcer or interventions for the care or treatment of the left heel unstageable wound.</p> <p>On 7/13/18 at 8:40 AM, the DON stated she did not know why there were no interventions for the pressure ulcer on the Care Plan. The DON stated</p>	F 656	<p>Inservices on proper care planning of wounds will reoccur weekly X2, then monthly X2.</p> <p>Wound care plan tracking will be completed by the new wound nurse and monitored by the Director of Nursing on PCC. DNS tracking will be daily X 10, weekly X 2, and then monthly X1.</p>		

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F 656	Continued From page 3 there should have been.	F 656			
F 680 SS=E	<p>Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D)</p> <p>§483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-</p> <p>(i) Is licensed or registered, if applicable, by the State in which practicing; and</p> <p>(ii) Is:</p> <p>(A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or</p> <p>(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or</p> <p>(C) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(D) Has completed a training course approved by the State.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and review of personnel files, it was determined the facility failed to ensure the activities program was directed by a qualified professional. This failure had the potential to compromise the mental and psychosocial well-being of all 49 residents residing in the facility, including Resident #1, if the activities program was not designed to accommodate their specific needs and interests. Findings include:</p> <p>On 7/12/18 at 9:34 AM, the Business Office Manager (BOM) who was responsible for</p>	F 680	<p>For all residents, existing certified Activity Director in the facility will provide and document a first week 2 hour oversight and 4 hours weekly oversight thereafter until the training Activity Director becomes certified.</p> <p>The weekly notes from supervising activity director which review assessments, notes, and other activity elements, will be brought to Quality Assurance Performance Improvement meeting monthly X 2, and then quarterly thereafter until training Activity Director is</p>	8/3/18	

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F 680	Continued From page 4 personnel files, stated the Activity Director was hired on 11/13/17. The BOM stated she could not find documentation of a completed Activity Director training program. Resident #1's record included a progress note, dated 5/9/18, written by the current Activities Director. The note was signed by the current Activities Director, with the title of "Activities Director". On 7/13/18 at 10:00 AM, the Administrator stated the Activity Director was going through the Activity Director training course as far as he knew. The Administrator stated the prior Activity Director worked at the facility as a CNA on an as needed basis, and provided a certificate verifying the prior Activity Director completed an Activity Director training program. The Administrator said the current Activity Director had used the prior Activity Director for mentoring and training, however, the prior Activity Director did not work in the activities program. Documentation of the mentoring or oversight of the current Activity Director, by the prior Activity Director, was not available or provided by the facility.	F 680	certified.		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		8/3/18	

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F 686	<p>Continued From page 5</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and review of a skin assessment spreadsheet, it was determined the facility failed to prevent the development and worsening of pressure ulcers. This was true for 1 of 3 residents (#1) reviewed for pressure ulcers. This failure resulted in harm to Resident #1 when she developed an unstageable pressure ulcer to her left heel. Findings include:</p> <p>Resident #1 was admitted to the facility on 1/26/17, with multiple diagnoses which included diabetes mellitus, stroke, major depressive disorder, recurrent severe with psychotic symptoms. A hospital discharge summary, with a print date of 1/13/18, documented Resident #1 was admitted to the ER (emergency room) from the facility on 1/10/18 following a fall with a left hip fracture. The summary stated Resident #1 was discharged from the hospital back to the facility on 1/13/18 following surgical repair of her left hip fracture.</p> <p>The Admit Nursing Assessment, dated 1/13/18 at 5:00 PM, documented Resident #1 was readmitted to the facility at 2:30 PM on 1/13/18. The assessment documented there were no abnormal skin areas on her feet, there were bruises on both of her arms, and a dressing was in place on Resident #1's hip which was dry and intact.</p>	F 686	<p>MD has assessed the wound on resident #1 and prescribed appropriate interventions which are implemented to the extent the resident allows. Resident is currently noncompliant with many of the care interventions that have been put in place. All treatments are on the Treatment Administration Record for this resident to ensure proper tracking of the wound and treatment changes. Resident is on alert charting to be reviewed and documented on daily.</p> <p>All pressure ulcer care will be documented on the Treatment Administration Record for all residents to ensure proper tracking of the wounds and treatment changes. Each resident with pressure ulcers will be on alert charting to be reviewed and documented on daily. The new wound nurse will submit a comprehensive skin care plan and update that will be reviewed by the skin committee a minimum of each month on all pressure wounds in the facility to ensure compliance and accuracy.</p> <p>A general education for all nurses has been made on 8/3/18 to teach on the need for accuracy in admission and other assessments, Placing all wound care on the Treatment Administration Record, placing all resident with pressure ulcers</p>		

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F 686	<p>Continued From page 6</p> <p>The annual Minimum Data Set (MDS) assessment, dated 1/31/18, documented Resident #1 was moderately impaired cognitively and required extensive assistance from 2 plus staff for bed mobility and transfers.</p> <p>Resident #1's Care Plan included a focus area of "Skin at risk," which was initiated on 2/9/17 and revised 5/9/18. The Care Plan included instructions, dated 1/19/18, to monitor the unstageable wound on Resident #1's left heel, which was present on her return from hospital. Interventions for the care and treatment of the wound were not included in Resident #1's Care Plan.</p> <p>Resident #1's Treatment Administration Record first directed staff with treatment to the left heel pressure ulcer on 3/22/18.</p> <p>A nursing progress note, documented by the MDS Coordinator on 1/19/18 at 11:35 AM, stated "Was asked to go to resident's room to observe something on her (Resident #1's) skin. In room, resident was lying on R (right) side as CNAs had just finished cares. They pointed to a dark area on her L (left) heel. I noted a dark purple fluid-filled area on the back of her L heel, obtained measuring tape and noted it to be 4.0 x 6.0 cm (and) unstageable." A nursing progress note at 11:45 AM on the same date, documented Podus boots (pressure relief) were to be placed on Resident #1's heels and the wound nurse was contacted regarding the pressure ulcer.</p> <p>A Weekly Body/Skin Check assessment, dated 1/22/18, documented left heel bruising that</p>	F 686	<p>on alert charting , and accuracy in documentation of time of assessments and other documentation.</p> <p>In service training on proper care and documentation of wounds on Treatment Administration Record, alert charting on all pressure wounds, will occur weekly X2, then monthly X2.</p> <p>Pressure wound care and other skin issues will be monitored by the Director of Nursing on PCC. DNS tracking will be daily X 10, weekly X 2, and then monthly X1. Skin issues will be brought to the Quality Assurance Performance Improvement committee quarterly</p>		

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F 686	<p>Continued From page 7</p> <p>measured 3.5 x 5.5 cm and was described as a suspected deep tissue injury. The form had RN #1's name in the top right corner of the first page.</p> <p>A nursing progress note, dated 1/23/18, documented the deep tissue injury on Resident #1's left heel measured 3.5 x 5.5 cm. The note also stated Resident #1 was wearing Podus boots and applied weight on her left leg.</p> <p>A progress note, dated 2/12/18, documented Resident #1 returned from the hospital with a deep tissue injury to her left heel that was improving, Podus boots were encouraged in bed, along with floating Resident #1's heels. The note documented Resident #1 continued to get around by pushing her wheelchair with her feet.</p> <p>A Doctor's Progress Note, dated 2/20/18, noted a pressure ulcer under Resident #1's left heel.</p> <p>A Podiatry Routine Foot Care Report, dated 2/28/18, documented an ulcer on Resident #1's left heel which was 4+ (plus) cm in diameter, debridement (removal) of black eschar (crusty dead tissue), and a good wound base.</p> <p>A nursing progress note, dated 3/7/18, documented Resident #1's left heel was progressing nicely and it measured 1.5 x 2.0 cm with a small amount of discharge noted.</p> <p>An Orthopedic Office Clinic Note, dated 3/14/18, documented Resident #1 had been in a Posey (pressure relief) boot for treatment of a heel ulcer and was minimally ambulatory. The Note documented the heel ulcer was resolving very nicely and was fully epithelialized (growth of</p>	F 686			

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F 686	<p>Continued From page 8 tissue just below the outer layer of skin).</p> <p>A Physician Assistant visit note, dated 3/16/18, documented Resident #1 was complaining of left foot pain and the Physician Assistant suspected it was due to the boot in place related to Resident #1's boggy heels. The visit note documented biofreeze was applied to Resident #1's foot and she was encouraged to continue using heel protectors.</p> <p>A nursing progress note completed by the wound nurse, dated 4/4/18, documented Resident #1's unstageable wound measured 1 x 1 cm and the wound bed was 100% adherent black eschar. The note documented duoderm paste was being replaced with Santyl to see if faster enzymatic debridement could be achieved.</p> <p>A Doctor's Note, dated 4/17/18, documented Resident #1's left heel pressure ulcer was healed and she was to continue using the walking boot.</p> <p>A nursing progress note, dated 4/24/18 at 4:45 PM, documented Resident #1's left foot was warm to the touch with slight edema (swelling) and that she often crossed her ankles. The note documented the licensed nurse educated Resident #1 of the risks and encouraged her to wear the boot at all times. The note documented the Resident often threw the boot across the room and refused to wear it.</p> <p>A nursing progress note, dated 4/24/18 at 11:13 PM, documented increased edema in Resident #1's legs and feet and her feet were shiny and became dark pink when in a dependent position. The note documented Resident #1 had a wound</p>	F 686			

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F 686	<p>Continued From page 9</p> <p>over her left heel and the skin of the foot was very warm to the touch. The note also included documentation that Resident #1 was able to self propel her wheelchair by using her feet and the physician was in to examine her and orders were written.</p> <p>A Doctor's Progress Note, dated 4/24/18, documented Resident #1 complained of left foot pain and swelling. The note stated Resident #1's pressure ulcer on her left heel was improving but the erythema (redness of the skin), swelling, and pain of her left foot was disconcerting. The note indicated the physician ordered an X-ray.</p> <p>A nursing progress note, dated 4/25/18, documented staff tried to educate Resident #1 to keep the boot on to protect her heel. The note documented Resident #1 would keep the boot on for approximately 30 minutes, then take it off and refuse to keep it on for about 2 hours. The note also indicated an X-ray was scheduled.</p> <p>A nursing progress note, dated 4/26/18, documented Resident #1 was encouraged to keep the boot on her left heel, but she did not like to do so.</p> <p>A nursing progress note, dated 4/30/18, documented Resident #1 used a wheelchair for locomotion and was able to self-propel with her feet.</p> <p>A dietary note, dated 5/3/18, documented Resident #1's left heel wound measured 1.0 x 1.5 cm and per the wound nurse, it was shrinking in size with stable eschar on the heel which would likely take a long time to debride.</p>	F 686			

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F 686	Continued From page 10 An MDS note, dated 5/9/18, documented Resident #1 was in the hospital in January 2018 and returned with an unstageable wound to the left heel. The note documented the wound was 1.0 x 1.5 cm eschar. A Condition Change Form, dated 6/29/18, requested a podiatry consult related to Resident #1's foot wound. A Physician Assistant visit note, dated 6/29/18, documented Resident #1's had a lesion that was not healing. The note directed staff to obtain a podiatry consult. A Physician Telephone Order, dated 7/3/18, documented the wound nurse requested the cancellation of the out of building podiatry consult and made arrangement for Resident #1 to be seen by the in-house podiatrist in August 2018. A nursing progress note, dated 7/1/18, documented Resident #1 generally went to bed just after 7:00 PM with complaints of left foot pain. The note documented Resident #1 requested Tylenol and went to bed with her left foot elevated. On 7/13/18 at 8:40 AM, the DON stated skin assessment sheets were completed by the certified wound nurse, RN #1. The DON said the skin assessment sheets were not kept in residents' paper or electronic medical records. The DON stated RN #1 kept them on a computer spreadsheet. The DON provided a spreadsheet titled Weekly Pressure Injury Record, which documented the pressure injury was present at	F 686			

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F 686	<p>Continued From page 11</p> <p>the time of Resident #1's readmission on 1/13/18, and included the following assessments of Resident #1's left heel wound:</p> <p>* 4/4/18 - 1 x 1 cm, no depth, no drainage, black eschar, non-stageable, no change in wound appearance, changing duoderm paste to Santyl</p> <p>* 4/14/18 - 1 x 1 cm, no depth, no drainage, black eschar, non-stageable, no change in wound appearance, slow debridement of Santyl will allow better control of wound bed and healing process.</p> <p>* 4/18/18 - 1 x 1 cm, no depth, no drainage, black eschar, non-stageable, no pain, eschar appears to be starting to soften at edges, remains stable with no major concerns, will continue with current treatment.</p> <p>* 4/25/18 - 1 x 1 cm, no depth, no drainage, black eschar, non-stageable, no pain, eschar appears to be starting to soften at edges, remains stable with no major concerns, will continue with current treatment.</p> <p>* 5/3/18 - 1 x 1 cm, no depth, no drainage, black eschar, non-stageable, no pain, eschar appears to be starting to soften at edges, remains stable with no major concerns, will continue with current treatment.</p> <p>* 5/10/18 - 1 x 1 cm, no depth, no drainage, black eschar, non-stageable, no pain, eschar has shrunk in size, approximately 70% remains and 30% yellow slough (dead tissue, usually cream or yellow in color) around edges.</p>	F 686			

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F 686	<p>Continued From page 12</p> <p>* 5/17/18 - 1 x 1 cm, 0.2 cm depth, yellow slough, non-stageable, no drainage, no pain, eschar in wound bed was loosely adhering, was able to mechanically debride with rigorous cleansing and completely remove remaining eschar, wound bed 100% yellow slough, will continue to use Santyl to debride slough from wound bed.</p> <p>* 5/24/18 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 100% yellow slough, non-stageable, no pain, no signs of infection, continue with current treatment.</p> <p>* 5/31/2018 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 90% yellow, 10% granulation tissue, non-stageable, no pain, no signs of infection, continue with current treatment.</p> <p>* 6/7/18 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 90% yellow, 10% granulation tissue, non-stageable, no pain, no signs of infection, continue with current treatment.</p> <p>* 6/14/18 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 80% yellow, 20% granulation tissue, non-stageable, no pain, no signs of infection, continue with current treatment.</p> <p>* 6/21/18 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 80% yellow, 20% granulation tissue, non-stageable, no pain, no signs of infection, continue with current treatment.</p> <p>* 6/28/18 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 75% yellow, 25% granulation tissue, non-stageable, no pain, no signs of infection, continue with current treatment.</p>	F 686			

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F 686	<p>Continued From page 13</p> <p>* 7/5/18 - 1 x 1 cm, 0.2 cm depth, yellow/scant drainage, 75% yellow, 25% granulation tissue, non-stageable, no pain, no signs of infection, continue with current treatment.</p> <p>The spreadsheet did not provide documentation from 1/19/18 to 4/4/18 of wound assessments for Resident #1's left heel pressure ulcer.</p> <p>On 7/13/18 at 8:40 AM, the DON stated she did not know why the weekly wound assessments were not started until 4/4/18 or why there were no interventions for the pressure ulcer on the Care Plan. The DON stated there should have been. The DON stated there was a Weekly Body/Skin Check assessment that was completed on Resident #1's day of admission which provided the documentation of the pressure ulcer, but she could not find it.</p> <p>On 7/13/18 at 12:15 PM, the DON provided a Weekly Body/Skin Check. It was dated 1/13/18 at 11:33 AM, and documented a 5 x 5 cm unstageable pressure ulcer to the left heel and a left heel tissue wound, not open, and her heels were floated. The form had the administrator's name in the top right corner of the first page.</p> <p>A nursing progress note, dated 1/13/18 at 3:51 PM, documented Resident #1 arrived back at the facility from the hospital at around 1:45 PM that day. Resident #1's Admit Nursing Assessment, dated 1/13/18 at 5:00 PM, documented Resident #1 was readmitted to the facility at 2:30 PM on 1/13/18. The time of completion of the 1/13/18 Weekly Body/Skin Check, was 11:33 AM, prior to Resident #1's return to the facility.</p>	F 686			

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F 686	Continued From page 14 On 7/13/18 at 12:40 PM, LPN #1 stated the initial skin assessments were completed on the Admit Nursing Assessment and Weekly Body/Skin Checks were started the week after a resident was admitted to the facility. LPN #1 stated she could not think of a reason to complete a Weekly Body/Skin Check assessment on the date of admission as the information would be documented on the Admit Nursing Assessment. On 7/13/18 at 2:00 PM, the DON stated Resident #1 was readmitted to the facility on 1/13/18 at 1:45 PM. The DON stated she did not know why the completion time of the Weekly Body/Skin Check was prior to the time of Resident #1's readmission to the facility.	F 686			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(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:	F 725		8/3/18	

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F 725	<p>Continued From page 15</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interviews, staff interviews, review of staff work hours, and record review, it was determined the facility failed to ensure there were sufficient numbers of staff to provide for the needs and well-being of residents. This was true for 3 of 3 residents (#3, #5, and #6) sampled for bathing when showers were not completed and placed 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 directed in residents' care plans, or otherwise needed. Findings include:</p> <p>On 7/12/18, the Punch Detail report for employees, which documented the number of hours staff actually worked, was provided for review. It showed the following:</p> <p>7/4/18 Census of 50 residents:</p> <p>Day Shift - 10 CNAs Evening Shift - 10 CNAs Nightshift - 5 CNAs</p> <p>6/23/18 Census of 48:</p> <p>Day Shift - 12 CNAs</p>	F 725	<p>For residents # 3, 5, and 6- On 7/23/18 there was initiated a bathing frequency audit. The audit requires a minimum of 2 baths per week for each resident. The individuals who worked the bath team have been incorporated to increase the staffing for the floor. Point Click Care Point of Care will ask every day if resident has been bathed or offered a bath. There will be required documentation on refusals or which type of bathing occurred. The Licensed Nurse will be responsible to review flags from incomplete documentation at the end of each CNA shift and ensure that CNAs complete the required documentation. On 7/23/18 there was initiated a bathing frequency audit. The audit requires a minimum of 2 baths per week for each resident.</p> <p>A staff retention program was started on 7/23/18 which involves The following: No new employee will be pulled to work on another wing before 30 days after their start date, thus allowing them to properly adjust to the required task; all part time and PRN employees have been</p>		

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F 725	<p>Continued From page 16</p> <p>Evening Shift - 6 CNAs and 3 Nursing Assistants Nightshift - 7 CNAs and 1 Nursing Assistant</p> <p>5/13/18 Census 51</p> <p>Day Shift - 11 CNAs Evening Shift - 8 CNAs and 2 Nursing Assistants Nightshift - 9 CNAs and 1 Nursing Assistant</p> <p>A list provided by the facility of residents requiring one to one supervision included five names. Two residents required one to one supervision 24 hours a day, two residents required one to one supervision 16-24 hours a day, and one resident was on a trial reduction to one to one supervision 16 hours a day.</p> <p>On 7/13/18 at 10:50 AM, the DON stated there should be a CNA for each resident requiring one to one supervision, two floor staff for each hall (2 on North Hall and 2 on South Hall), a front door monitor 24 hours a day, one Hall Monitor for completing every 15 minutes checks, and one CNA to help with staff breaks. The DON stated the Nursing Assistants worked with CNAs, so they were assisting them and were not normally counted in the staffing.</p> <p>The DON stated she would check to see if staff missed clocking in on those days. At 1:00 PM on 7/13/18, the DON stated there were no employees that did not clock in.</p> <p>Given the above information provided by the DON, each shift needed 12 CNAs on duty, to meet residents' needs. Of the 3 days reviewed, one shift, the day shift on 6/23/18, had 12 CNAs on duty. The other 8 eight shifts, counting CNAs and Nursing Assistants, were short 1 to 7 staff.</p>	F 725	<p>interviewed and many have indicated that they will change to full time once a fair rotation of job duties is initiated. Fair rotation of job duties and staffing audits will be signed off by the DNS and/or ADNS as assignment sheets are produced by the Lead CNA. All assignment sheets will have a certification as staff signs, acknowledging that they are working the shift of their own free will. Training on the Point of Care kiosks 7/24/18 through 7/27/18 to ensure documentation on bathing and refusals. Fair rotation audits were implemented on 7/30/18 to ensure all CNA and NA staff are treated fairly in covering shift and not giving preference to other individuals. All Fair rotation audits, staffing audits and bathing frequency audits are to be brought to the IDT weekly X2, then to the quality assurance committee monthly X2</p>		

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F 725	Continued From page 17 The facility's Shower/Tub Bath policy, last revised September 2014, stated: "... Documentation - The following information should be recorded on the residents ADL [activities of daily living] record and/or in the resident's medical record: * The date and time the shower/tub bath was performed. * The name and title of the individual(s) who assisted the resident with the shower/tub bath. * All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. * How the resident tolerated the shower/tub bath. * If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. * The signature and title of the person recording the data..." 1. Resident #3 was admitted to the facility on 6/26/18 with multiple diagnoses including diabetes mellitus, stroke with hemiplegia, and dementia. Resident #3's MDS assessment, dated 7/3/18, documented she was severely cognitive impaired and required extensive assistance from one person for bathing. Resident #3's July 2018 Bath Sheet documented	F 725			

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F 725	<p>Continued From page 18 from July 1 - July 13, Resident #3 received one bath, on 7/10/18.</p> <p>2. Resident #5 was admitted to the facility on 12/27/17, with multiple diagnoses including depression and anxiety.</p> <p>Resident #5's quarterly MDS assessment, dated 7/13/18, documented she was cognitively intact and required extensive assistance from one person for bathing.</p> <p>Resident #5's July 2018 Bath Sheet documented from July 1 - July 13, 2018, Resident #5 received 2 baths, on 7/7/18 and 7/11/18.</p> <p>On 7/13/18 at 12:40 PM, Resident #5 stated she had not had a shower in two weeks.</p> <p>3. Resident #6 was admitted to the facility on 9/28/15, with diagnoses of seizures, hemiplegia (weakness or paralysis on one side of the body), and dementia.</p> <p>Resident #6's quarterly MDS assessment, dated 4/17/18 documented she was cognitively intact and required extensive assistance from one person for bathing.</p> <p>On 7/13/18 at 11:30 AM, Resident #6 stated she wanted to get 3 showers a week but there were times when the shower team got pulled to work on the floor.</p> <p>On 7/13/18 at 11:45 AM, the MDS Coordinator stated she was sure it was not an issue with residents receiving baths, but a documentation issue.</p>	F 725			

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F 725	Continued From page 19 On 7/13/18 at 1:52 PM, DON stated an expectation that residents would be bathed "ideally, two times a week." When asked if that was happening, the DON stated "Not that we can prove by the documentation." The DON stated an expectation that if the shower aide was not there, that showers were still to be done. On 7/13/18 at 1:25 PM, the Regional Vice President of Clinical Services (RVPCS) stated her expectation was that residents were bathed twice a week. If a resident refused, staff would re-approach the resident several times and then offer the resident a bed bath. The RVPCS stated if something was not documented as completed, it was the same as it not being done.	F 725			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		8/3/18	

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

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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 C 07/13/2018
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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F 842	<p>Continued From page 20</p> <p>(iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p>	F 842			

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F 842	<p>Continued From page 21</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 1 of 6 sample residents (#1) whose records were reviewed. This created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information in the resident's clinical record. Findings include:</p> <p>Resident #1 was admitted to the facility on 1/26/17 with multiple diagnoses which included diabetes mellitus, stroke, major depressive disorder, recurrent severe with psychotic symptoms. A hospital discharge summary, with a print date of 1/13/18, documented she was admitted to the ER (emergency room) from the facility on 1/10/18 following a fall with a a left hip fracture. The summary stated Resident #1 was discharged from the hospital back to the facility on 1/13/18 following surgical repair of her left hip fracture.</p> <p>a. The Admit Nursing Assessment, dated 1/13/18 at 5:00 PM, documented Resident #1 was readmitted to the facility at 2:30 PM on 1/13/18. The assessment documented there were no</p>	F 842	<p>All treatments are on the Treatment Administration Record for resident#1 to ensure proper tracking of the wound and treatment changes. Resident is on alert charting to be reviewed and documented on daily. All wound assessments will be part of the permanent medical record.</p> <p>Education of the 2 nurses that made errors in documenting assessments and time frames for completion of assessments has been made. A general education for all nurses has been made on 8/3/18 to teach on the need for accuracy in admission and other assessments, and accuracy in documentation with proper time frames.</p> <p>An audit of all recent admissions (6 months) has been made to ensure assessments are accurate and closed at the time of the assessment.</p> <p>All admissions going forward will also be audited by the Director of Nursing or the Assistant Director of Nursing to ensure all assessments are complete, accurate and</p>		

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F 842	<p>Continued From page 22</p> <p>abnormal skin areas on her feet, there were bruises on both of her arms, and a dressing was in place on Resident #1's hip which was dry and intact.</p> <p>A nursing progress note, dated 1/19/18 at 11:35 AM, documented a dark purple fluid filled area on the back of Resident #1's left heel that measured 4.0 x 6.0 cm that was unstageable.</p> <p>A Weekly Body/Skin Check assessment, dated 1/22/18, documented Resident #1 had left heel bruising that measured 3.5 x 5.5 cm and was described as a suspected deep tissue injury.</p> <p>On 7/13/18 at 8:40 AM, the DON stated there was a Weekly Body/Skin Check assessment that was completed for Resident #1 on 1/13/18, the day of her readmission, which included documentation of the pressure ulcer, but she could not find it.</p> <p>On 7/13/18 at 12:15 PM, the DON provided a Weekly Body/Skin Check. It was dated 1/13/18 at 11:33 AM, and documented a 5 x 5 cm unstageable pressure ulcer on Resident #1's left heel and a left heel tissue wound, which was not open, and her heels were floated.</p> <p>A nursing progress note, dated 1/13/18 at 3:51 PM, documented Resident #1 arrived back at the facility from the hospital at around 1:45 PM that day. Resident #1's Admit Nursing Assessment, dated 1/13/18 at 5:00 PM, documented Resident #1 was readmitted to the facility at 2:30 PM on 1/13/18. The time of completion of the 1/13/18 Weekly Body/Skin Check, was 11:33 AM, prior to Resident #1's return to the facility.</p>	F 842	<p>timely. The assessment review will be brought to the Quality Assurance Committee monthly X2.</p>		

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F 842	<p>Continued From page 23</p> <p>On 7/13/18 at 2:00 PM, the DON stated Resident #1 was readmitted to the facility on 1/13/18 at 1:45 PM. The DON stated she did not know why the completion time of the Weekly Body/Skin Check was prior to the time of Resident #1's readmission to the facility.</p> <p>b. On 7/13/18 at 8:40 AM, the DON stated skin assessment sheets were completed by the certified wound nurse, RN #1. The DON said the skin assessment sheets were not kept in residents' paper or electronic medical records. The DON stated RN #1 kept them on a computer spreadsheet. The DON provided a spreadsheet titled Weekly Pressure Injury Record, which documented multiple assessments of Resident #1's left heel wound.</p> <p>Resident #1's medical record did not include skin assessment sheets completed by the wound nurse.</p>	F 842			