



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

February 5, 2020

Michael Moreno, Administrator
Mini-Cassia Care Center
PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Moreno:

On **January 29, 2020**, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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) and on or before the "Opportunity to Correct." **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.

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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 Plan of Correction (PoC) for the deficiencies must be submitted by **February 18, 2020**. Failure to submit an acceptable PoC by **February 18, 2020**, may result in the imposition of penalties by **March 9, 2020**.

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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 4, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 29, 2020**. A change in the seriousness of the deficiencies on **March 14, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 29, 2020** includes the following:

Denial of payment for new admissions effective **April 29, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 29, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; 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. 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 29, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<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 18, 2020**. If your request for informal dispute resolution is received after **February 18, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN,, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 02/28/2020
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 01/29/2020
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 000	INITIAL COMMENTS The following deficiencies were cited during a complaint survey conducted at Mini Cassia Care Center from January 28, 2020 through January 29, 2020. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Brad Perry, LSW Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse NA = Nursing Assistant RN = Registered Nurse	F 000			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		2/17/20	

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

TITLE

(X6) DATE

Electronically Signed

02/14/2020

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 583	<p>Continued From page 1</p> <p>the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and resident and staff interview, it was determined the facility failed to ensure a resident's privacy and private health information was protected during a blood glucose (BG) check. This was true for 1 of 4 residents (Resident #1) reviewed for privacy. This failure created the potential for residents to experience a decreased sense of self-worth when his blood glucose level was checked in the dining room and the results audibly announced loud enough for others in the dining room to hear. Findings include:</p> <p>The facility's blood glucose (BG) level policy and Quality of Life policy, dated 7/21/17 and 5/2015 respectfully, directed staff to provide privacy for residents during BG checks and keep clinical information confidential. These policies were not followed.</p>	F 583	<p>F583 Confidentiality of Medical Records</p> <p>It is the intent of the facility to ensure that the resident's medical records are secure and confidential.</p> <p>Resident 1 was assessed and experienced no adverse effects due to the lack of adherence to resident's privacy and private health information remaining secure and confidential. Resident rights of privacy were reviewed with Resident 1.</p> <p>RN 1 was provided education regarding ensuring resident's privacy and private health information remain secure and confidential. Resident rights of privacy were reviewed with RN 1.</p>		

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F 583	Continued From page 2 Resident #1 was admitted to the facility on 5/31/19, with multiple diagnoses including diabetes. On 1/29/20 at 4:00 PM, Resident #1 was in his wheelchair at a table in the North dining room. RN #1 approached Resident #1 and told him that she was going to check his BG level. RN #1 did not offer to take him to a private setting. She completed a finger stick BG test and announced the BG test results loud enough to be heard in the North dining room. There were two other residents in the North dining room area during the test. On 1/29/20 at 4:05 PM, Resident #1 was in the dining room and said nurses usually checked his BG level, "out here." On 1/29/20 at 4:25 PM, RN #1 said she did not offer to take Resident #1 to a private setting and performed the BG check in the dining room. RN #1 said she announced his BG during the test. On 1/30/20 at 10:30 AM, the DNS said she expected licensed staff to perform BG checks in a private area and not to announce the results for others to hear.	F 583	The Administrator will hold a Resident Council with all residents and review residents' rights to privacy and private health information to remain secure and confidential by 2-17-2020. The Director of Nursing conducted and audit of all residents requiring blood glucose via fingerstick to ensure that the residents' privacy and private health information remain secure and confidential. The Director of Nursing conducted an in-service with licensed nursing staff regarding the confidentiality of medical records (verbal, written, or EMR), Obtaining a Blood Glucose Via Fingerstick policy, and resident rights of privacy. The Director of Nursing/Designee will conduct weekly focused rounds to ensure that residents' medical records remain secure and confidential, resident right of privacy are upheld, and the blood glucose via fingerstick is be obtained per policy. The Director of Nursing/Designee will conduct weekly focused rounds to ensure that residents' medical records remain secure and confidential and resident rights of privacy until Quality Assurance Committee decreases the frequency of audits. Identified trends will be reviewed/reported to the facility Quality Assurance		

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F 583	Continued From page 3	F 583			
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure adequate supervision for 1 of 4 residents (Resident #2) who were reviewed for supervision. This failure placed the residents at risk of injury from falling. Findings include:</p> <p>Resident #2 was readmitted to the facility on 11/22/19, with multiple diagnoses including epilepsy and a history of falls.</p> <p>An Incident and Accident Report, dated 12/28/19 at 8:00 AM, documented Resident #2 was sitting in the common area, stood up, lost his balance, and was assisted to the floor by a staff member. Resident #2 was assessed and no injuries were noted. The report documented the immediate intervention was to assign a CNA for one-to-one (1:1) supervision at all times for Resident #2.</p> <p>An Interdisciplinary Team (IDT) Progress Note, dated 12/31/19 at 12:15 PM, documented a review of the Incident and Accident Report for the</p>	F 689	<p>Committee monthly and as needed until lesser frequency is deemed appropriate.</p> <p>F689 Free of Accident Hazards/Supervision/Devices</p> <p>It is the intent of the facility to ensure the resident's environment remains as free from accidents/hazards as possible and that each resident receives adequate supervision to prevent accidents.</p> <p>Resident 2 was assessed and experienced no adverse effects due to lack of adherence to 1:1 policy or plan of care.</p> <p>CNA 1 was educated regarding the 1:1 policy and following the plan of care which defines the task/duties of the 1:1.</p> <p>The Director of Nursing conducted an audit of all residents receiving 1:1 service to ensure that they are receiving the necessary care and services to remain free from accidents/hazards as possible</p>	2/17/20	

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F 689	<p>Continued From page 4</p> <p>fall on 12/28/19. The note stated Resident #2 had a change of condition and required 1:1 supervision.</p> <p>Resident #2's care plan, dated 12/31/19, documented Resident #2 required 1:1 supervision at all times.</p> <p>On 1/28/20 at 2:45 PM, Resident #2 was observed leaning over the head of his bed tucking in the sheets from his bed. CNA #1 was observed sitting in a chair with a bedside table over her lap at the foot of Resident #2's bed. CNA #1 stated she was assigned to Resident #2 as a 1:1 due to his frequent falls.</p> <p>On 1/28/20 at 3:08 PM, the Resident Services Director stated Resident #2 required 1:1 supervision at all times related to having a change of condition that caused him to fall.</p> <p>On 1/28/20 at 3:40 PM, the DNS stated the assigned 1:1 for Resident #2 needed to be within arms reach of him at all times. The DNS stated Resident #2 gets up quickly and would lose his balance and fall.</p> <p>On 1/28/20 at 3:49 PM, Resident #2 was observed laying down in bed and CNA #1 was at the foot of his bed sitting in a chair with a bedside table over her lap. CNA #1 stated she needed to be within arms reach of Resident #2 because he got up quickly and loses his balance. CNA #1 stated if Resident #2 got up from laying down, she would have moved the bedside table quickly to assist him. CNA #1 stated she was not in arms reach of Resident #2 when he was making his bed.</p>	F 689	<p>and that each 1:1 resident is receiving adequate supervision to prevent accidents.</p> <p>The Director of Nursing conducted an in-service with all staff regarding 1:1 policy and following the plan of care which defines the task/duties of the 1:1.</p> <p>The Director of Nursing/Designee will conduct weekly focused rounds to ensure the resident's environment remains as free from accidents/hazards as possible and that each resident receives adequate supervision to prevent accidents until the Quality Assurance Committee decreases the frequency of the audits.</p> <p>Identified trends will be reviewed/reported to the facility Quality Assurance Committee monthly and as needed until lesser frequency is deemed appropriate.</p>		

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F 689	Continued From page 5	F 689			
F 732 SS=C	<p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or</p>	F 732		2/17/20	

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F 732	<p>Continued From page 6</p> <p>written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure nurse staffing information was posted daily and kept for review for 18 months. This failed practice had the potential to affect the 48 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include:</p> <p>The facility's Nurse Staffing Information policy, dated 6/2018, documented the facility posted the following information at the beginning of each shift: total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for residents' care per shift; and to maintain the posted daily staffing data for a minimum of 18 months. This policy was not followed.</p> <p>On 1/28/20 from 12:05 PM to 3:30 PM, the daily nurse staffing information was observed in the South hallway across from the nurses' station. The information was on a dry erase board and documented the resident census was 48 for that day. There were areas to document the staffing information for RNs, LPNs, CNAs, and NAs for</p>	F 732	<p>F 732 Posted Nurse Staffing Information</p> <p>It is the intent of the facility to post Nurse Staffing Information that includes the facility name, the current date, the total numbers and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift (Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides, and Resident census). During the survey process the Nurse Staff Information was updated and posted immediately.</p> <p>The Director of Nursing was educated on a new process to maintain the nurse staffing information. The process was changed to record the nurse staffing information on a formalized document that is posted in a plastic sheet near the South Nursing station daily. At the end of every night shift that form is saved and placed in office of the Director of Nursing Services. That form will be maintained there for a timeframe of eighteen months.</p> <p>The Director of Nursing conducted an</p>		

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F 732	Continued From page 7 the day, evening, and night shifts. There was no data listed under these areas. On 1/28/20 at 3:30 PM and 3:40 PM, the DNS said the nurse staffing posting board did not have the staffing information written on it. She said she expected the hall monitor staff to complete the information. She said she could not produce previous posting information because the posting information had not been retained.	F 732	in-service with licensed staff regarding posting Nurse Staff Information that includes the facility name, the current date, the total numbers and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift (Register nurses, Licensed Practical Nurses, Certified nurse aides, and Resident census). The Director of Nursing/Designee will conduct weekly focused rounds to ensure posting of Nurse Staff Information that includes the facility name, the current date, the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift (Registered Nurses, Licensed Practical Nurses, Certified Nurse aides, and Resident census) until the Quality Assurance Committee decreases the frequency of audits. Identified trends will be reviewed/reported to the facility Quality Assurance Committee monthly and as needed until lesser frequency is deemed appropriate.		