



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 30, 2019

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

Provider #: 135081

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Radeke:

On **April 23, 2019**, a Facility Fire Safety and Construction survey was conducted at **Mini-Cassia Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread 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. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 13, 2019**. Failure to submit an acceptable PoC by **May 13, 2019**, may result in the imposition of civil monetary penalties by **June 4, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 28, 2019**, (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 **July 22, 2019**. A change in the seriousness of the deficiencies on **June 7, 2019**, 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 **May 28, 2019**, includes the following:

Denial of payment for new admissions effective **July 23, 2019**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 23, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 23, 2019**, 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:

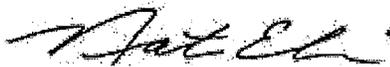
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **May 13, 2019**. If your request for informal dispute resolution is received after **May 13, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

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FORM APPROVED
OMB NO. 0938-0391

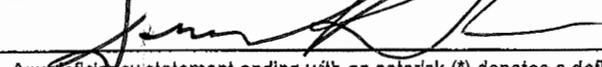
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG-BEHAVIOR CARE UNIT B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2019
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER		STREET ADDRESS, 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)	(X6) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single-story type V (000) building built in 1974, with a partial basement. The building is fully sprinklered and is protected throughout by an interconnected fire alarm/smoke detection with off-site monitoring. Backup emergency power is provided by and onsite, spark-ignited natural gas generator, upgraded in April 2019. The partial basement houses staff support services such as laundry, maintenance shop and miscellaneous offices. The facility is currently licensed for 68 SNF/NF beds, and had a census of 49 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 23, 2019. The facility was surveyed under the Life Safety Code, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and, such liability is hereby specifically denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p>	
K 324 SS=D	<p>Cooking Facilities CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3/ 19.3.2.5.3,</p>	K 324	<p>The facility will ensure compliance with Life Safety Code and NFPA standards by installing a trim that prevents exhaust from bypassing the hood filters on the kitchen hood system on 5/7/19. The hood filter bypass prevention has been placed on the weekly maintenance room round sheet. The weekly range exhaust system maintenance report will be brought to the QAPI committee monthly X 2, then quarterly X 1 to ensure compliance.</p>	5/7/19

RECEIVED
MAY 16 2019
FACILITY STANDARDS

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

TITLE

(X8) DATE



ADMINISTRATOR

5/13/19

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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K 324	<p>Continued From page 1</p> <p>or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure kitchen hood systems were maintained in accordance with NFPA 96. Failure to ensure grease laden vapors do not bypass hood filters could allow grease build-up inside the exhaust system, increasing the risk of grease fires. This deficient practice affected staff and visitors of the main Kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 4/23/19 from approximately 1:00 - 2:00 PM, observation of the main Kitchen hood system revealed a gap of approximately 3/4 inch between the filter and the edge of the hood on the left hand side and a gap of approximately 1/2 inch between the filter and the edge of the hood on the right hand side, allowing exhaust air to bypass the filters.</p> <p>Actual NFPA standard: NFPA 96</p>	K 324		

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K 324	Continued From page 2 6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters.	K 324		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression sprinkler pendants were maintained free of obstructions such as paint, dirt and corrosion. Failure to maintain fire suppression pendants free of obstructions has the potential to hinder system response during a fire event. This deficient practice affected staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 4/23/19 from	K 353	K353 The facility will ensure that the automated sprinkler system is inspected, tested and maintained by NFPA 25 standards this will be done by using a flashlight to inspect sprinkler heads for corrosion that may not be seen with the regular lighting in the room and the sprinkler heads will be exchanged in accordance with the requirements. 1) Sprinkler heads on the back stairs leading to the exit to grade, basement laundry in front of dyers, and 2) the pendent above the dishwasher are scheduled to be replaced by Delta Fire Systems on or before 6/9/2019. The facility maintenance manager will monitor sprinkler heads in sync with the monthly schedule, using the flashlight to assist and paying attention to outside pendants and pendants that may be exposed to condensation (i.e. the kitchen and shower rooms). The documentation will be brought to the quality assurance team for review Monthly X 2, then Quarterly X 1.	5/10/19

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K 353	<p>Continued From page 3</p> <p>11:30 AM - 2:00 PM, observation of installed fire suppression pendants revealed the following:</p> <p>1) In the basement level, the back stairs leading to the exit to grade revealed one (1) painted pendant and one (1) pendant loaded with dirt and debris.</p> <p>2) In the main Kitchen, the sprinkler pendant above the dishwasher was revealed to be corroded.</p> <p>Interview of the Maintenance Supervisor established he was not aware of these obstructed pendants prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers.</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 353		
K 363 SS=F	<p>Corridor - Doors</p> <p>CFR(s): NFPA 101</p>	K 363		

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K 363	<p>Continued From page 4</p> <p>Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:</p>	K 363	<p>K363</p> <p>The facility will ensure that door closures will be maintained in accordance with NFPA standards.</p> <p>The latching mechanism was repaired on 4/23/2019. The facility maintenance manager will make weekly rounds and document the completion of the rounds to ensure that doors protecting corridor openings latch appropriately.</p> <p>The facility maintenance manager will complete the door latch checks on a weekly basis and the documentation will be brought to the quality assurance team for review monthly X 2, then quarterly X 1.</p>	4/23/19

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K 363	Continued From page 5 Based on observation and operational testing, the facility failed to ensure corridor doors entering resident rooms would latch. Failure to ensure latching for resident room doors entering the corridor, has the potential for smoke, fire and dangerous gases to pass between compartments, affecting the safe egress of residents during a fire. This deficient practice affected 19 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on 4/23/19 from 10:00 AM - 12:00 PM, observation and operational testing of resident room doors revealed the door to room 11 would not close and latch properly. Actual NFPA standard: 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511		

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K 511	<p>Continued From page 6 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure approved and safe electrical installations were in accordance with NFPA 70 and listed assemblies. Use of relocatable power taps (RPT) with large appliances or equipment not within its listed assembly, has been historically linked to arc fires in facilities. This deficient practice potentially affected staff and visitors on the date of the survey.</p> <p>Findings include: During the facility tour conducted on 4/23/19 from 11:00 AM - 12:00 PM, observation of the full-size refrigerator in the basement staff break area, revealed the appliance was using a RPT to supply power from the outlet.</p> <p>Actual NFPA standard: NFPA 70 110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed. 110.3 Examination, Identification, Installation, and</p>	K 511	<p>K511</p> <p>The facility will ensure compliance with NFPA 54 and 70 standards by moving the basement refrigerator to access the direct plug.</p> <p>This was accomplished on 5/6/2019.</p> <p>The facility maintenance manager will ensure proper use of electrical outlets in the basement which has been placed on the weekly maintenance room round sheet. The weekly electrical and maintenance report will be brought to the QAPI committee monthly X 2, then quarterly X 1 to ensure compliance.</p>	5/6/19

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K 511	<p>Continued From page 7</p> <p>Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(1) Suitability for installation and use in conformity with the provisions of this Code</p> <p>Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>Additional reference:</p>	K 511		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BLDG-BEHAVIOR CARE UNIT B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2019
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)	(X6) COMPLETION DATE
K 511	Continued From page 8 UL 1363 Standard for Relocatable Power Taps	K 511		

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C 000	<p>INITIAL COMMENTS</p> <p>The facility is a single-story type V (000) building built in 1974, with a partial basement. The building is fully sprinklered and is protected throughout by an interconnected fire alarm/smoke detection with off-site monitoring. Backup emergency power is provided by and onsite, spark-ignited natural gas generator, upgraded in April 2019. The partial basement houses staff support services such as laundry, maintenance shop and miscellaneous offices. The facility is currently licensed for 68 SNF/NF beds, and had a census of 49 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 23, 2019. The facility was surveyed under the IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities and the Life Safety Code, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	C 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 16 2019</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
C 260	<p>02.106.07,h Weekly Cleaning of Range Hoods/Filters</p> <p>h. All range hoods and filters shall be cleaned at least weekly. This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to ensure that kitchen hood filters were cleaned on a weekly basis. Failure to clean hood filters weekly has the potential for grease fire due to excessive grease build-up. This deficient</p>	C 260		<p>C260 The facility will ensure that the range hood in the kitchen is cleaned on a weekly schedule by placing the cleaning on the kitchen's written cleaning schedule.</p> <p>The facility maintenance manager will ensure proper cleaning and documentation of the hood cleaning and document it on the rounding sheet which will be brought to the quality assurance team for review monthly X 2, then quarterly X 1.</p>

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X8) DATE



ADMINISTRATOR **5/13/19**

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C 260	Continued From Page 1 practice affected staff and visitors of the main Kitchen on the date of the survey. Findings include: During the facility tour conducted on 4/23/19 from 1:00 - 2:00 PM, observation of the weekly cleaning schedule posted in the main Kitchen, did not indicate a schedule for weekly cleaning of the hood filters. When asked about the cleaning of the hood filters, the Dietary Manager stated this was a routine cleaning procedure, but was not on the schedule and there was no documentation demonstrating this procedure was performed weekly. Actual IDAPA standard: 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. 07. Maintenance of Equipment. The facility shall establish routine test, check and maintenance procedures for all equipment. h. All range hoods and filters shall be cleaned at least weekly.	C 260		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 30, 2019

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

Provider #: 135081

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Radeke:

On **April 23, 2019**, an Emergency Preparedness survey was conducted at Mini-Cassia Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

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

Printed: 04/29/2019
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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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E 000	<p>Initial Comments</p> <p>The facility is a single-story type V (000) building built in 1974, located in a rural fire district with both county and state EMS support services available. The building is fully sprinklered and is protected throughout by an interconnected fire alarm/smoke detection with off-site monitoring. Backup emergency power is provided by and onsite, spark-ignited natural gas generator, upgraded in April 2019. There is a partial basement that houses staff support services such as the laundry, maintenance shop, and miscellaneous offices. The facility is currently licensed for 68 SNF/NF beds, and had a census of 49 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on April 23, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.