STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135081	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mini-Cassia Care Center	1729 Miller Street East Burley, ID 83318

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50603 Based on observation, review of the Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM), Appendix PP, and resident and staff interviews, it was determined the facility failed to ensure the residents had an environment where housekeeping and maintenance services provided a sanitary shower room in good repair. This was true for 1 of 4 showers used in the facility. This deficient practice created the potential for psychosocial harm if residents felt they were not provided the same homelike environment as other residents. Findings include: On 5/27/25 at 5:10 PM, it was observed the main shower in the south wing had brown and black spots resembling mold on the floor of the shower and near the drain. The shower chairs had a ring of red built up residue on the underside portion of the seat. The edge of the shower wall bar did not have an end cap cover, and a sharp metal ridge was observed. On 5/30/25 at 10:33 AM, the CRN and DON stated the shower was in disrepair and should have been closed. The DON stated there would not be a build-up of mold/dirt if the showers were cleaned between uses and deep cleaned every day. On 5/30/25 at 11:15 AM, the Administrator confirmed the main shower room on the south wing was not clean or in good repair.

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.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on review of the Resident Assessment Instrument (RAI) Manual, record review, and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) assessment included correct information. This was true for 2 of 14 residents (#2 and #20) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not monitored due to inaccurate assessments. Findings include: The RAI Manual, revised 10/1/24, documented section A1500, PASRR (Preadmission Screening and Resident Review), was to be coded yes when a PASRR level II screening determined a resident had a serious mental illness and/or intellectual disability, or related condition. 1. Resident #2 was admitted to the facility on [DATE], for care following a fracture and had multiple diagnoses including bipolar disorder (a mental health condition characterized by extreme mood swings including emotional highs or lows) and generalized anxiety disorder. Resident #2's medical record included documentation of a PASRR level I screening, dated 8/6/24, which identified she had serious mental illness diagnoses of bipolar disorder and anxiety. Resident #2's medical record included documentation of an abbreviated PASRR level II screening, dated 8/6/24, which identified she had diagnoses of serious mental illness per PASRR criteria. Resident #2's Admission MDS Assessment, dated 8/7/24, documented section A1500, PASRR Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability, or a related condition? The answer for this question was documented as no. On 5/29/25 at 3:17 PM, the Regional MDS Nurse stated, Resident #2 has a PASRR level II, so the MDS at A1500 should be answered yes to reflect her serious mental illness diagnoses. 50603 2. Resident #20 was admitted to the facility on [DATE], with multiple diagnoses including bipolar disorder. An Annual MDS Assessment, dated 3/23/25, documented no at A1500, a PASRR level II was not completed. Resident #20's medical record included documentation of a PASRR level I screening, dated 8/20/21, which identified she had a serious mental illness diagnosis of bipolar disorder. Resident #20's medical record included documentation of an abbreviated PASRR level II screening, dated 8/23/21, which identified she had a diagnosis of serious mental illness per PASRR criteria. On 5/29/25 at 3:28 PM the Regional MDS Nurse stated in 2021, Resident #20's MDS documented yes at A1500, a PASRR level II had been completed, but beginning in 2022, it was marked no in error and it should have been corrected.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 50603 Based on review of the CMS SOM, Appendix PP, record review, and staff interview, it was determined the facility failed to ensure 1 of 14 residents (Resident #21), mental health needs were evaluated through the State's level II PASRR process. This deficient practice had the potential to cause harm if the resident's mental health needs were not adequately met. Findings include: Resident #21 was admitted to the facility 8/16/23, with multiple diagnoses including major depressive disorder and post-traumatic stress disorder (PTSD). A PASRR level II, dated 8/16/23, documented, A 30-day exemption rehabilitation - if [Resident #21] stays (30 days) past admission, please submit most current MDS, physician's order, social notes and psych[iatric] information to [agency name]. If discharged , please notify [agency name] per information below. A PASRR level II, dated 5/13/25, documented Resident #21 had serious mental health diagnoses including depression, anxiety, PTSD, and the PASRR level II was forwarded to [agency name] for further review. On 5/29/25 at 10:42 AM the Administrator stated Resident #21 had received a 30-day PASRR level II exemption due to medical issues. An updated PASRR level II was completed on 5/13/25. On 5/29/25 at 1:44 PM, the Resident Services Director (RSD) stated Resident #21 was given a 30-day exemption on admission for a PASRR level II, and the PASRR level II should have been submitted when Resident #21 stayed past 30-days in September 2023.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 50981 Based on staff interview and record review, it was determined the facility failed to ensure PASRR's were completed for 1 of 14 residents (Resident #40) reviewed for PASRR's. This deficient practice had the potential for more than minimal harm when if residents required, but did not receive, specialized services for mental health while residing in the facility. Findings include: Resident #40 was admitted to the facility 5/6/22, with multiple diagnoses including Alzheimer's disease, depression, and anxiety. A Psychiatric Progress Note, dated 6/24/22, documented Resident #40 had mental health diagnoses of anxiety, insomnia, and dementia with behavioral disturbances and was taking Trazodone (antidepressant medication) 25 mg at bedtime and Seroquel (antipsychotic medication) 50 mg at bedtime. Resident #40's PASRR level I from Nevada documented No MI [mental illnesses], MR [intellectual disability], RC [related conditions] or Dementia, and was not referred for further evaluation. Resident #40's care plan, initiated on 5/19/22, documented she had Alzheimer's and dementia with behavior disturbances, anxiety, restlessness, and agitation. Interventions included administer antidepressant and antipsychotic medications. Resident #40's Admission MDS Assessment, dated 5/13/22, documented the following: -She was not cognitively intact. -She had hallucinations and delusions with behavioral symptoms directed at others (threatening, screaming, cursing at others), and her behavioral symptoms significantly interfered with her participation in activities or social interactions. -She received antipsychotic medication on 7 out of the 7 previous days. On 5/29/25 at 3:15 PM, the Regional MDS Nurse stated, the Nevada PASRR level I for Resident #40 was wrong. She added, this resident should have had a PASRR Level I and II for Idaho when she was admitted to the facility, and the facility did not complete them.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a baseline care plan was developed within 48 hours of residents' admission. This was true for 2 of 14 residents (#1 and #27) reviewed for baseline care plans. This failure created the potential for harm if the care plan failed to provide direction for care. Findings include: The facility's Baseline Care Plans policy (undated) documented a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. 1. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia, anxiety disorder, and neuroleptic induced parkinsonism (a condition where individuals develop parkinsonian symptoms as a side effect of taking certain medications). Resident #1's medical record did not document a baseline care plan was completed. On 5/29/25 at 1:26 PM, the DON stated a baseline care plan was not completed for Resident #1. 50603 2. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including low back pain, fracture of the right leg, altered mental status, diabetes, and opioid dependence. Resident #27's medical record did not document a baseline care plan was completed. On 5/29/25 at 1:28 PM, the DON stated a baseline care plan was not completed for Resident #27.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on observation, record review, the CMS SOM review, and staff interview, it was determined the facility failed to ensure resident centered care plans were comprehensively written. This was true for 1 of 14 residents(Resident #34) whose care plans were reviewed. This deficient practice placed the resident at risk for harm when their care plan did not reflect the care necessary. Findings include: Resident #34 was admitted to the facility on [DATE], for care following a stroke affecting her right side, with multiple diagnoses including diabetes, high blood pressure, and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing irreversible lung and airway damage making it hard to breathe). On 5/28/25 at 8:34 AM, Resident #34 stated the swelling in her right leg had increased over the past few weeks, and elevating her legs in bed helped a little bit, but not enough. Physician's orders, dated 8/27/22, documented give Lasix 40 mg (a diuretic) by mouth in the morning for edema. Physician's orders, dated 4/17/24, documented the following: - Aldactone 25 mg (a diuretic): Give 1 tablet by mouth in the morning for edema. - Lasix 40 mg: Give 40 mg by mouth one time a day for edema. - Lasix 20 mg: Give 20 mg by mouth one time a day for edema. Resident #34's care plan did not document any interventions or treatment planning related to edema. On 5/30/25 at 10:15 AM, the DON stated Resident #34's edema treatment and interventions were not care planned, and they should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on record review and staff interview, it was determined the facility failed to ensure services provided met professional standards. This was true for 1 of 14 residents (Resident #43) whose physician orders were reviewed. This failure placed Resident #43 at risk for harm from overmedication when his seizure medication orders were not clarified. Findings include: Resident #43 was admitted to the facility on [DATE], with multiple diagnoses including a seizure disorder, dementia with agitation, and right sided hemiplegia (a form of paralysis to one side of the body). Resident #43's record documented the following physicians' orders for controlled substance emergency seizure medications, dated 11/22/24: - lorazepam oral concentrate 2 mg/ml, give 1 ml by mouth as needed for seizures, may repeat 1 time in 15 minutes if seizure activity continues, - midazolam nasal solution 5 mg/0.1 ml, give 1 spray in 1 nostril every 10 minutes as needed for non-intractable epilepsy (seizures that can be managed medically, either through medication, surgery, or other treatments). On 5/30/25 at 11:30 AM, the DON stated Resident #43's emergency seizure medication orders should have included directions for which medication to administer first, were not specific enough, and needed to be clarified.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50981 Based on record review, medication error reports, and staff interview, it was determined the facility failed to ensure residents were protected from significant medication errors. This was true for 5 of 5 residents (#10, #23, #31, #34, and #44) reviewed for medication errors. This deficient practice created the potential for harm if residents received medications not as prescribed. Findings include: 1. Resident #10 was admitted to the facility on [DATE] with multiple diagnoses including, Alzheimer's disease, schizophrenia, and muscle spasms. Resident #10's record documented a physician's order for lorazepam 2 mg/ml, give 0.5 ml twice a day for anxiety. A Medication Error and Analysis report, dated 12/23/24, documented Resident #10 received 1 ml of lorazepam in error on the following dates and times: -On 12/21/24 at 5:00 AM -On 12/21/24 at 12:00 PM -On 12/21/24 at 7:00 PM -On 12/22/24 at 12:00 PM On 5/30/25 at 9:30 AM, the DON confirmed Resident #10 was administered the wrong dose of lorazepam on 12/21/24 and 12/22/24. 2. Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including, seizures, alcohol abuse, and nicotine dependence. Resident #23's record documented a physician's order for Norco (a narcotic pain medication) 10-325 mg, one tablet twice per day for pain. A Medication Error and Analysis report, dated 3/4/25, documented a medication error occurred on 3/4/25. Resident #23 was administered another resident's Norco 5-325 mg in error. On 5/30/25 at 9:33 AM, the DON confirmed Resident #23 was administered the wrong dose of Norco on 3/4/25. 3. Resident #31 was admitted to the facility on [DATE], with multiple diagnoses including arthritis of left shoulder, anxiety, and schizophrenia. Resident #31's record documented a physician's order for Norco 5-325 mg, one tablet four times a day for pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication Error and Analysis report, dated 1/6/25, documented a medication error occurred on 1/6/25. Resident #31 was administered another resident's Norco 10-325 mg. On 5/30/25 at 9:36 AM, the DON confirmed Resident #31 was administered the wrong dose of Norco on 1/6/25. 4. Resident #34 was admitted to the facility on [DATE], with multiple diagnoses including stroke, diabetes, and arthritis of the left shoulder. Resident #34's record documented a physician's order for Norco 5-325 mg, one every 6 hours as needed for pain. A Medication Error and Analysis report dated 1/21/25, documented a medication error occurred on 1/21/25 when Resident #34 was administered another resident's Norco 10-325 mg. On 5/30/25 at 9:39 AM, the DON confirmed Resident #34 was administered the wrong dose of Norco on 1/21/25. 5. Resident #44 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia, diabetes, and opioid dependence. Resident #44's record documented a physician's order for lorazepam 1 mg, one time a day for anxiety. A Medication Error and Analysis report dated 4/9/25, documented a medication error occurred on 4/9/25. Resident #44 was administered oxycodone 10 mg and did not receive their lorazepam as prescribed. On 5/30/25 at 9:42 AM, the DON confirmed Resident #44 was administered the wrong medication on 4/9/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50603 Based on observation, FDA Food Code, and staff interview, it was determined the facility failed to ensure kitchen equipment was cleaned. These deficiencies had the potential to affect the 56 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes. Findings include: The FDA Food Code Section 4-602.12 Cooking and Baking Equipment documented food-contact surfaces of cooking equipment must be cleaned to prevent encrustation's that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use. On 5/30/25 at 10:40 AM, it was observed the baking sheet used to make honey buns had a black residue along the edge of the pan, which flaked off with minimal abrasion. Two skillets had a ring of dark, encrusted residue around the majority of the pan's interior and exterior surfaces. The dark, encrusted residue did not scrape off. On 5/30/25 at 10:55 AM, the Food Services Manager stated the pans should not have the black, encrusted coating, and they should be replaced.