

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
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 08/05/2026
NAME OF PROVIDER OR SUPPLIER Mini-Cassia Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 Miller Street East Burley, ID 83318	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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. Based on observation, interview, policy review, and U.S. Food and Drug Administration 2022 Food Code, the kitchen staff failed to appropriately store and label foods, wash hands prior to donning gloves, and prevent possible cross contamination of opened resident stored food items with kitchen stored food products. This deficient practice had the potential to affect all 58 residents who received meals prepared in the facility's kitchen. Findings include: The facility's Food Receiving and Storage policy dated 3/31/25, documented all foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. On 8/3/26 at 9:45 AM, observed the following in the kitchen: Reach-in refrigerator: - An opened bag of lettuce with a used by date (UBD) of 8/2/26. - A container of pink liquid (punch) with no open or UBD dates. - Various opened food items with residents' names on them stored in the kitchen refrigerator; tomato cocktail, cream cheese, potato salad, jar of mayonnaise, package of sandwich bologna. Reach-in Freezer: - An opened bag of frozen egg omelets with no open or UBD. - An opened bag of pizzas with no open or UBD. Panty: - An opened vanilla syrup 1 gallon container with a UBD of 6/17/26. - An opened 12 oz pancake syrup bottle with a UBD of 8/2/26. On 8/3/26 at 3:23 PM, observed [NAME] #1 with ungloved hands, carry some food product to the trash can, lift the lid with her bare hands and push the food product down into the trash can to crush the garbage down. She then went back to her cooking duties without washing her hands to include pouring soup into bowls for the residents. On 8/4/26 at 2:35 PM, observed [NAME] #2 cutting up celery with gloved hands. When she changed tasks to open a cupboard and move some bowls around, then returned to the cutting task and without changing gloves or hand hygiene she picked up the cut up celery to put in the bowl. [NAME] #2 took off one glove so she could get her glasses to read the recipe for the dinner meal. She then obtained another glove and donned it without washing her hands and then went back to food preparation. On 8/4/26 at 3:30 PM, the Maintenance Manager (acting food service manager) stated all food items in the refrigerator/freezers should have been labeled with UBD and proper hand hygiene practices need to be followed by kitchen staff and were not.		

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, resident, and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 4 of 8 residents (#4, #13, #19, and #44) reviewed for respect and dignity. This deficient practice placed residents at risk of embarrassment and diminished sense of worth. Findings include: The facility's Assistance with Meals policy dated March 2022, documented facility staff will serve resident trays and will help residents who require assistance with eating. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. The facility's Dignity policy dated February 2021, documented that each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights. For example, resident are provided with a dignified dining experience. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's Disease (a progressive disease of the nervous system that affects movement) and major depressive disorder. Resident #13 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech, and behavior) and abnormal involuntary movement (uncontrolled body motions that include tremors, chorea, and dystonia). Resident #19 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including spastic quadriplegic cerebral palsy (the most severe form of cerebral palsy, affecting all four limbs, the trunk, and the face) and anxiety disorder. Resident #44 was admitted to the facility on [DATE], with multiple diagnoses including traumatic brain injury and dysphagia (difficulty swallowing). On 8/3/26 at 11:20 AM, observed eight residents in the assistive dining room during the lunch meal, with only four of the residents being assisted with eating their meal which had been delivered. Residents #4, #13, #19, and #44 were not served their lunch tray until after 12:10 PM (more than 50 minutes past the posted lunch mealtime). These residents were observed to be watching those who were being assisted with eating their lunch meals. On 8/3/26 at 1:05 PM, the DON stated Residents #4, #13, #19, and #44 should have been served their lunch meal tray at the same time as the other residents or not been brought into the dining room until their trays were ready.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure a resident's call light was within reach for 5 of 18 Residents (#29, #50, #51, #56, and #57) reviewed for residents' rights. This deficient practice had the potential to cause harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include: The facility's Answering the Call Light policy, revision date September 2022, documented. Ensure the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. Resident #51 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including acquired absence of left leg below knee, bipolar disorder (extreme mood swings), and anxiety disorder. On 8/3/26 at 10:26 AM, observed Resident #51's call light button was under his bed which was against the wall and not accessible to him, so he had no way of calling for help if needed. Resident #56 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke, traumatic brain injury, and Alzheimer's disease. On 8/3/26 at 10:31 AM, observed Resident #56 was lying in her bed without her call light button which was hanging from a hook on the wall about five feet high to the right of the head of bed out of her reach and not accessible. Resident #56's bed is very low to the ground, and she cannot self-ambulate or get out of bed and without the call light button she could not call for help because she does not verbally communicate. On 8/4/26 at 3:45 PM, the RNC stated the call light buttons should be accessible to Resident #51 and #56 at all times and were not. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (chronic mental health condition featuring a combination of hallucinations or delusions and mood disorders), post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event), and diabetes. On 8/3/26 at 10:47 AM, and 8/4/26 at 8:16 AM, observed Resident #29 lying in her bed with her call light plugged into the electrical outlet on the wall above the bed near the foot of Resident #29's bed. The call light was hanging down the wall at the foot of the bed and was resting on the floor under Resident #29's bed and not within her independent reach. On 8/4/26 at 8:17 AM, LPN #2 stated Resident #29's call light should be within reach and had not been. Resident #57 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (chronic mental health condition featuring a combination of hallucinations or delusions and mood disorders), anxiety, and unsteadiness on feet. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/3/26 at 10:09 AM, observed Resident #57 lying in her bed with her call light plugged into the electrical outlet on the wall above her bed with the cord coiled up and pinned to itself and not within Resident #57's independent reach. On 8/4/26 at 4:57 PM, the RNC stated Resident #57's call light should have been within reach and had not been. Resident #50 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression and mania), and obsessive-compulsive disorder (a mental health condition characterized by unwanted thoughts that lead to repetitive behaviors). On 8/4/26 at 8:12 AM, observed Resident #50 lying in his bed with his call light plugged into the electrical outlet on the wall near the foot of his bed coiled up and pinned to itself and not within Resident #57's reach. On 8/4/26 at 8:14 AM, LPN #2 stated Resident #57's call light should be within reach and had not been. On 8/5/26 at 8:41 AM, the DON stated residents' call light should be within the resident's reach and had not been.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all 58 residents who resided in the facility whose equipment and environment were observed. This deficient practice created the potential for harm if: a) cross contamination due to equipment not being cleaned between use b) residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, undignified, or c) residents were injured due to unsafe areas in the facility. Findings include: The facility's Cleaning and Disinfection of Environmental Surfaces policy, revision date August 2019, documented environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogens Standard. The Facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy, revision date September 2022, documented Resident care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. The facility's Maintenance Service policy dated December 2009, documented that the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include maintaining the building in good repair and free from hazards. The following areas were observed for clean and homelike environment: On 8/4/26 at 8:46 AM, observed North Hall shower room: -Shower stall #1 floor with dark black residue in the separation of the lower portion of the shower stall and the flooring. -Shower stall #2 flooring with dark residue in the chipped and open penetration along the floor measuring from one side of the shower stall to the drain located between shower stall #1 and shower stall #2. On 8/4/26 at 5:27 PM, the Maintenance Manager stated he was aware of the shower room flooring issues and knew the showers needed to be repaired. The following areas were observed for safety issues: On 8/3/26 at 10:07 AM, observed plastic door panels on the outside of room [ROOM NUMBER] and room [ROOM NUMBER], with plastic edge protruding. On 8/5/26 at 9:40 AM, the maintenance director stated the panels needed to be fixed. On 8/3/26 at 3:20 PM, observed in the south hall shower room, two large holes that were missing tile about 6 inches wide by 12 inches long and 1/8 inch deep and a smaller crack about 1 inch wide by 2 (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inches long and 1/8 inch deep. Potential for a wheeled shower chair to tip from if wheel was caught in the hole. On 8/4/26 at 3:15 PM, the maintenance manager stated he had been watching this shower area and knew the flooring needed to be corrected The following areas were observed for facility cleanliness: On 8/3/26 at 9:54 AM, observed on the north hallway: - the vent at the end of the north hallway had a black substance and a cobweb-like substance - the ceiling around the vent had a gray fuzzy substance - the two vents outside room [ROOM NUMBER] with gray fuzzy substance - the wall at the end of the north hall with multiple gouges On 8/3/26 at 11:19 AM, observed in the north side dining room across from the TV room: - ceiling vent grates with a black substance - yellow, dry splattering substance on first ceiling light and on ceiling around the light - the second ceiling light had rust colored dry splattering The following areas were observed for equipment cleanliness: On 8/3/26 at 10:59 AM, Resident #46's wheelchair had dried, red, chunky substance to center of cushion, and splattering of dried, white substance to cushion. Right wheel lock of wheelchair, had a large chunk of dried, tan colored substance. All four wheels had a large amount of hair accumulated in wheel mechanism. On 8/3/26 at 11:01 AM, Resident #38's wheelchair had large, dried brown substance splattered on front left wheel. All four wheels had a large amount of hair accumulated in wheel mechanism. On 8/3/26 11:02 AM, CNA #3 stated night shift should have cleaned the wheelchairs. On 8/5/26 at 9:05 AM, the DON stated staff should clean wheelchairs on night shift. On 8/3/26 at 10:07 AM, observed in room [ROOM NUMBER]: - a mattress on the floor beside resident's bed with thick, dried, brown substance and smearing of dried, white substance (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- another mattress leaning against the wall with large amount of dried white substance - an isolation bin containing soiled linen with no cover - large gouges in wall between closets - bedpan on the floor uncovered under the sink - dark substance smeared on the wall by resident # 38's bed - cracked light cover containing multiple bugs - unknown dried, brown substance spilled on floor - dried yellowish colored substance on bed sheets On 8/3/26 at 10:17 AM, observed in room [ROOM NUMBER]: - Dried brown, sticky substance on floor - gouges along railing around bed - cracked light fixture - no door leading to the bathroom - thick black substance to room entrance threshold - mat at bedside covered with dried, brown substance On 8/3/26 at 11:47 AM, observed a bedside table in north side dining room/tv room with large amount of dry, brown substance on the base. On 8/3/26 at 3:00 PM, review of the facility's Deep Cleaning Logs and Environmental Services Checklist for Daily Cleaning of Resident Room forms did not include documentation of cleaning of vents in the hallway, mats and mattresses at resident's bedside. On 8/5/26 at 9:45 AM, the Housekeeping Supervisor stated there is a daily cleaning schedule and the vents should have been cleaned but it would have taken a ladder to reach them. She also stated the housekeepers should be cleaning the floors daily. On 8/5/26 at 9:51 AM, the Housekeeping Supervisor stated the nurse aides are required to clean BM, vomit, and blood off the mattresses and mats at the resident's bedside and then housekeeping cleans the mattress or mat. She also stated the bedside table should be cleaned daily whether they are in the resident's room or in the dining room.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility's Bowel Management - Clinical Protocol, record review, and staff interview, it was determined the facility failed to follow facility bowel care Clinical Protocol of delivering specific medications when residents do not have BM within 72 hours for 3 of 6 Residents (#4, #31 and #56) who records were reviewed for bowel and bladder care. This failed practice created the potential for residents to experience discomfort when medications were not administered according to the physician's order. Findings include: The facility's Bowel Management - Clinical Protocol dated April 2026, documented the facility shall assess, monitor, and manage bowel and bladder function for all residents according to individualized needs, physician/provider orders, and applicable regulations. Intervention Protocol: DAY 2 NO BM: Encourage fluids, Licensed Nurse to offer prunes, prune juice or 2 Tablespoons of BAP po BID from dietary. Administer Senokot 8.6 mg one tab po BID today. DAY 3 NO BM: Encourage fluids, offer prune juice or 2 tablespoons of BAP po BID from dietary. Administer Senokot 8.6mg one tab po BID and Glycolax 17 GM in 8oz fluid po BID today. DAY 4 NO BM: Encourage fluids, Licensed Nurse to offer prunes, prune juice or 2 Tablespoons BAP po BID from dietary. Administer Senokot 8.6mg one tablet po BID, Glycolax 17GM po BID, Lactulose 30cc po BID and Dulcolox suppository 10mg per rectal in early AM today. If no BM by noon of day 4, notify physician for further instructions. Report any liquid stools with no formed BM to MD. DAY 5 NO BM: Continue to offer prunes, prune juice or BAP 2 Tablespoons po BID, Senokot 8.6mg po BID, Glycolax 17 GM in 8oz fluid BID, Lactulose 30cc's po BID. If no BM Licensed Nurse to complete assessment, listen to bowel tones, abdominal distention, check rectal vault per nursing standards. If no BM by 2 p.m. on Day 5 notify MD for further orders. Resident #31 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (a serious mental health condition that affects how people think, feel, and behave, including hallucinations, delusions, and disorganized thinking) and alcohol abuse. On 8/4/26 at 3:21 PM, Resident #31's medical record documented no BM from 7/27/26 at 2146 to 7/31/26 at 2130, and no documented nursing interventions related to lack of BM during this same time period. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including Parkinson's Disease (a progressive disease of the nervous system that affects movement) and major depressive disorder. On 8/3/26 at 3:57 PM, Resident #4's medical record documented no BM from 7/9/26 to 7/12/26 and no documented nursing interventions related to lack of BM during this same time period. Resident #56 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke, traumatic brain injury, and Alzheimer's disease. On 8/3/26 at 2:52 PM, Resident #56's medical record documented no BM from 7/21/26 to 7/28/26 and 7/29/26 to 8/2/26 and no documented nursing interventions related to lack of BM during this same time period. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/26 at 7:15 AM, the RNC stated Resident #4, #31 and #56 medical records had no documented BM related interventions for July and the first part of August 2026 and should have.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and policy review, it was determined the facility failed to ensure residents' representatives were immediately notified when residents fell or had a change in condition. This was true for 2 of 4 Residents (#7 and #57) whose records were reviewed for changes in condition. This deficient practice placed residents at risk of harm due to lack of advocacy and support from their representatives when they were unable to make decisions for themselves due to decreased health status and level of consciousness. Findings include: The facility's Change in a Resident's Condition or Status policy, revised date February 2021, documented facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). Resident #7 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including major depressive disorder, dementia, and anxiety. On 8/4/26 at 4:17 PM, review of Resident #7's medical record had documented a progress note dated, 7/26/26 at 00:27, Post Fall Evaluation: Date and Time of Fall: 7/25/26 12:28 AM. Resident #7 went to walk out of the doorway in the t.v. room, lost balance, and fell. A laceration to Resident #7's chin was noted. Provider notified 7/25/26 of resident's fall. On 8/4/26 at 4:22 PM, review of Resident #7's medical record documented a Nurses Note dated 7/26/26 at 00:19, Orders from Provider to place steri strips to laceration under chin, observe Q shift until chin is healed. Observe for further latent injuries from fall with vitals for the next 72 hours. Resident #7's medical record had not documented her representative was notified of her fall at the time of the event. Resident #57 was admitted to the facility on [DATE], with multiple diagnoses including schizophrenia (chronic mental health condition featuring a combination of hallucinations or delusions and mood disorders), anxiety, and unsteady on feet. On 8/4/26 at 5:02 PM, review of Resident #57's medical record documented a Nurses Note dated 4/19/26 at 00:07, Resident had a witnessed fall in her room, Provider and DON notified of falling. there is a skin tear to her left upper arm that measures 3cm x 1cm. Orders received to change dressing to left upper arm with Opti foam every 3 days until resolved. Resident #57's medical record had not documented her representative was notified of her fall at the time of the event. On 8/5/26 at 8:42 AM, the DON stated the residents' representative should have been notified at the time of the event and had not been.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure resident's right were protected to be free from abuse. This was true for 1 of 1 resident (Resident #56) observed during lunch assistive feeding. This failure placed all residents at risk for potential abuse and potential physical and psychosocial harm. Findings include: The facility's Resident Abuse Procedural Summary policy dated May 2017, documented BRP takes a number of measures to prevent resident abuse and neglect such as inspecting the facility's physical environment, placing cameras in certain areas of the facility, close supervision of staff and contractors, and care planning. The facility's Abuse Policy dated 5/31/17, documented residents are to be free from abuse, neglect, misappropriation of resident property, and exploitation. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur, such as; the deployment of staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual resident's care needs. On 8/3/26 at 11:38 AM, the surveyor was standing about 3 feet from the lunch table, when he heard CNA #1 aggressively slap Resident #56's left wrist and witnessed CNA #1 grab Resident #56's left wrist and roughly pulled her hand off of his shirt sleeve that she had grabbed. The surveyor continued to observe the assistive feeding of residents and then reported this issue to the DON and Administrator around 1:10 PM. CNA #1 was hired at the facility on 3/4/24 and had signed the facility Resident Abuse Procedural Summary on 3/9/24. CNA #1 attended Behavior Training on 3/24/26. CNA #1 had received three disciplinary actions since his employment with the facility, with the last one on 10/20/25, for assistive feeding a resident too large of a bite from a food tray that was not appropriate for the resident. The resident choked and required assistance to include Heimlich maneuver to remove the food item from the resident throat. CNA #1 was suspended for 5 days from work following this incident and was required to attend or retake a feeding assistance class. CNA #1 completed the Assisted Dining: The role and Skills of Feeding Assistants Course on 11/5/25. On 8/3/26 at 1:18 PM, the Administrator stated CNA #1 had been suspended and sent home pending investigation. On 8/3/26 at 2:40 PM, the Administrator stated Resident #56 had been assessed by a licensed nurse and there were no bruises or cuts on her wrists. On 8/4/26 at 10:38 AM, the DON stated CNA #1 should not have slapped or grabbed Resident #56's wrist when this issue happened but should have asked for help if needed and had not.		

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NAME OF PROVIDER OR SUPPLIER Mini-Cassia Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1729 Miller Street East Burley, ID 83318	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure resident's care plans were revised to reflect current needs and interventions. This was true for 1 of 18 residents (Resident #55) whose care plan was reviewed. This placed residents at risk of adverse outcomes if care and services were not provided due to care plans not being revised as residents' needs changed. Findings include: The facility's Comprehensive Person-Centered Care Plan policy, revised March 2022, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments are ongoing, and care plans are revised as information about the residents and the residents' conditions change. Resident #55 was admitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure with hypoxia (a condition where the respiratory system slowly loses its ability to bring enough oxygen into the blood) and diabetes. A physician's order dated 4/21/25, documented compression stocking to right leg on AM, off PM every morning and at bedtime for edema. A physician's order dated 6/7/26, documented administer O2 at 1-2 L/min continuously via nasal cannula as resident will allow, every day and night shift related to chronic respiratory failure with hypoxia. On 8/4/26 at 11:15 AM, Resident #55 was observed in her room with portable liquid oxygen unit on the back of her wheelchair and oxygen concentrator at bedside. She was not wearing oxygen or compression stockings. On 8/4/26 at 11:20 AM, CNA #2 stated Resident #55 did not have oxygen on and she should have. Review of resident #55's care plan had not documented the use of oxygen or compression stockings. On 8/4/26 at 3:00 PM, the DON stated Resident #55's care plan had not documented the use of oxygen or compression stockings and it should have. She also stated any refusals should be documented and they had not been.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, policy review, and Occupational Safety and Health Administration (OSHA) Standard, it was determined the facility failed to ensure residents were free from accident hazards for 2 of 18 Residents (#15 and #41) whose room was observed for environmental safety. This deficient practice had the potential to cause physical harm if a power strip cord were to overheat and cause a fire. Findings include: The facility's Electrical Safety for Residents policy, reviewed date 8/2026, documented 8. Power strips shall not be used with medical devices in resident care areas. The Occupational Safety and Health Administration Standard 29 CFR S 1910.303(b)(2), documented power strips must be used only in accordance with manufacturer instructions and listings, which strictly prohibit covering them with bedding, placing them on flammable surfaces, or exposing them to heat accumulation and physical damage. Resident #41 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including, hemiplegia (loss of function to one side of the body), epileptic seizures, and anxiety. On 8/3/26 at 10:32 AM, observed Resident #41 lying in his bed with three electrical cords plugged in to a power strip that had been placed on his pillow at the head of his bed surrounded by other bed linens. On 8/3/26 at 10:40 AM, Resident #41 stated he used the power strip to keep his cell phone and other personal equipment charged because he could not reach the wall outlet. On 8/4/26 at 5:10 PM, the RNC stated the power strip should not have been placed on Resident #41's bed. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including, schizoaffective disorder (chronic mental health condition featuring a combination of hallucinations or delusions and mood disorders) and hypertension (high blood pressure). On 8/4/26 at 11:25 AM, observed a nebulizer machine sitting at the foot of Resident #15's bed on top of the bed linen and plugged in to a power strip at the wall outlet. On 8/4/26 at 11:29 AM, LPN #1 stated there is a shortage of power outlets in Resident #15's room and she would not allow staff to plug the nebulizer in at the wall outlet at the head of her bed so the nebulizer machine could be placed on her side table so the nebulizer machine was plugged in to a power strip at the foot of Resident #15's bed and the nebulizer machine placed on her bed on top of the bed linens. On 8/4/26 at 2:13 PM, Resident #15's medical record documented a physician order for Albuterol Sulfate Inhalation Nebulizer Solution - 1 vial inhale orally via nebulizer four times a day for pneumonia for 7 days. Order date - 8/1/26. On 8/4/26 at 5:12 PM, the RNC stated the power strip should not have been used for the nebulizer machine, and the nebulizer machine should not have been placed on Resident #15's bed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents (Resident #6) received continuous oxygen via nasal cannula prescribed by the physician. This created the potential for residents to experience respiratory difficulties/impaired breathing and low oxygen saturations. Findings include: The facility's Oxygen Administration policy dated February 2024, documented Preparation staff will verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration. Steps in the Procedure, turn on the oxygen.start the flow of oxygen at the rate of 2 to 3 liters per minute. Place appropriate oxygen device on the resident ie, nasal cannula.Resident #6 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness).On 8/3/26 at 10:17 AM, observed Resident #6 sitting in a wheelchair in his room without his oxygen cannula on and CNA #1 standing next to him. CNA #1 stated he was taking Resident #6 out of his room but was waiting for his portable oxygen unit to be filled. When the liquid oxygen unit arrived, CNA #1 attached the oxygen tubing to the unit and applied the nasal cannula to Resident #6 but did not turn on the liquid portable oxygen unit. On 8/3/26 at 10:26 AM, CNA #1 wheeled Resident #6 in his wheelchair to the nurse's station down the hallway and waited for the nurse to turn the liquid portable on to his liter flow. Resident #6's physician's oxygen order dated 6/25/26, documented Oxygen 2L to 4L NC continuous.Resident #6's care plan documented oxygen as per physicians ordered. Check room air saturation as ordered, wean as able/ordered.On 8/4/26 at 4:40 PM, the RNC stated the CNA should not have taken Resident #6 off his oxygen but should have had the nurse set the liquid portable unit at the proper litter flow before putting it on the resident and did not.		

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Form Approved OMB
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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on review of the State Operations Manual, Appendix PP dated 7/23/25, policy review, staffing schedules, personnel files, and staff interviews, it was determined the facility failed to ensure full-time employees working as a nurse aide successfully completed a State approved training and competency evaluation program within 4 months of being hired. This was true for 1 of 1 nurse aides (NA #1) whose personnel files were reviewed. This failure had the potential to result in negative outcomes for all residents living in the facility. Findings include: The facility's Nurse Aide (NA) and Certified Nurse Aide (CNA) Hiring Policy dated August 2026, documented an individual may not be employed as a nurse aide for more than four months unless the individual has met the applicable federal and state requirements for nurse aide employment. On 8/5/26 at 7:47 AM, Nurse Aide #1's personnel file was reviewed and documented NA #1 was hired by the facility on 10/1/25 but had not started a CNA course. On 8/5/26 at 8:15 AM, the HR Director stated NA #1 is scheduled to begin classes on 8/17/26. The HR Director stated NA #1 should have completed the course within 120 days of hire and had not.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was accurate and posted daily for each shift. This failed practice had the potential to affect all residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: The State Operation Manual, Appendix PP dated 7/23/25, documented S483.35(g) Nurse Staffing Information. S483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (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: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. On 8/5/26 at 11:00 AM, observed the Daily Staffing sheets for 5/1/26 through 8/4/26 noting they had not contained the following required information: - None of the daily staffing sheets included the actual hours worked by RNs, LPNs, and CNAs.- Many of the daily staffing sheets had not documented the Facility's name. On 8/5/26 at 2:30 PM, the Administrator and RNC stated the required information was missing from the daily staffing sheets.		

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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** Based on observation, interviews, and policy review, the facility failed to ensure residents were free of medication preparation and administration errors for 1 of 2 residents (Resident #8) observed for medication preparation and administration of insulin. This failed practice placed the resident at risk for not receiving their prescribed medication dosage and other adverse outcomes. Findings: The facility's Insulin Administration policy, reviewed date 4/2023, documented Preparation: 4. The nursing staff have access to specific instructions (from the manufacturer, if appropriate) on all forms of insulin delivery systems prior to their use. Insulin Delivery: 3. Pens - containing insulin cartridges deliver insulin subcutaneously through a needle. Prime the pen according to manufacturer instructions. Manufacturer Instructions for Use documented. Priming your Pen - Prime before each injection, if you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your pen, turn the dose knob to select 2 units. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (stroke), aphasia (inability to express oneself through speech), and diabetes. Resident #8's physician order dated 1/19/26, documented Humalog OG Kwik Pen Subcutaneous Solution (Lispro) Pen-injector 100 units/ml - Inject 5 units subcutaneously before meals for Type 2 diabetes. On 8/4/26 at 11:14 AM, observed LPN #1 remove Humalog (Lispro) insulin pen from the medication cart and dial the insulin pen to 5 units as ordered. LPN #1 did not prime the insulin pen with 2 units before dialing the ordered dose. On 8/4/26 at 11:15 AM, LPN #1 administered the Humalog (Lispro) insulin to Resident #8. On 8/4/26 at 11:18 AM, LPN #1 stated she did not prime the insulin pen and was unaware of the need to prior to administering insulin. On 8/4/26 at 11:23 AM, the DON stated insulin pens should be primed, according to the manufacturer's instructions, and had not been.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and policy review, it was determined the facility failed to ensure medications were properly stored and not expired. This was true for the facility. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include: The facility's policy, Administering Medications, revised date March 2025, documented.13. The expiration/beyond use date on the medication label is checked prior to administering. The following was observed during the medication cart audits. On 8/4/26 at 8:57 AM, the South Hall medication cart was audited with LPN #1 present. Observed the following: - one bottle of Colace gel tablets with a manufacturer expiration date of 7/26 printed on the bottle. On 8/4/26 at 8:59 AM, LPN #1 stated the bottle of Colace gel tablets should have been discarded and had not been. On 8/4/26 at 11:41 AM, the DON stated the expired medication should have been removed from the medication cart and had not been.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and U.S. Food and Drug Administration 2022 Food Code review, the facility failed to ensure garbage cans were properly closed with lids to minimize attracting pests and rodents into the kitchen. This deficient practice had the potential to affect all residents and staff in the facility. Findings include: The FDA Food Code Section 5-501.113 Covering Receptacles documented receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (A) Inside the food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the food establishment. On 8/3/26 at 10:03 AM, observed the following in the kitchen main food prep area:- 55 gallon trash can with a hole cut in the lid so it cannot be securely closed. The trash can was overflowing with trash. The FDA Food Code Section 5-501.116 Cleaning Receptacles documented proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 8/4/26 at 9:45 AM, observed the following outside of the kitchen just in the alleyway:- The larger trash cans outside in the alley had two lids wide open and some empty box material on the ground just outside of the kitchen. On 8/4/26 at 1:38 PM, the RNC stated the kitchen garbage cans need to have a tight-fitting lid without holes and the garbage cans outside in the alley should always have their lids closed and had not.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 3 of 3 residents (#6, #15, and #56) observed for infection control. These failures put residents at risk for cross contamination and infection. Findings include: The facility's Administering Medications through a Small Volume (Handheld) Nebulizer policy, reviewed date 8/2026, documented Steps in the Procedure - 29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. The facility's Assistance with Meals policy, revised date March 2022, documented . All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. Resident #15 was admitted to the facility on [DATE], with multiple diagnoses including schizoaffective disorder (chronic mental health condition featuring a combination of hallucinations or delusions and mood disorders) and hypertension (high blood pressure). A physician order, dated 8/1/26, documented Resident #15 was to receive Albuterol Sulfate Inhalation Nebulizer Solution 1 vial inhale orally via nebulizer four times a day for pneumonia for 7 days. Resident #15's MAR, dated 8/1/26 through 8/31/26, documented Resident #15 was receiving the nebulizer treatments four times a day as ordered. On 8/4/26 at 11:26 AM, Resident #15's nebulizer equipment was observed lying on her bed, dry and not in use, and unbagged. On 8/4/26 at 11:28 AM, LPN #1 stated Resident #15's nebulizer should have been stored in a bag when not in use and had not been. On 8/4/26 at 5:03 PM, the RNC confirmed the equipment was not appropriately bagged after use to prevent contamination of the equipment and should have been. Resident #6 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness). Resident #56 was initially admitted to the facility on [DATE], and was readmitted to the facility on [DATE], with multiple diagnoses including stroke, traumatic brain injury, and Alzheimer's disease. On 8/3/26 at 11:20 AM, observed CNA #1 using his right hand to assist two different residents eat their lunch meal by picking Resident #6's spoon, scoop up a small amount of mashed potatoes and place the spoon in his mouth, then with the same hand and no hand hygiene conducted, pick up Resident #56's spoon and scoop a small amount of her potatoes and place the spoon in her mouth. CNA #1 did this action 4 times before using his left hand to assist Resident #6 and his right hand to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assist Resident #56. CNA #1 also wiped both resident's mouths after several bites of food with their own cloth napkin without gloves or any hand hygiene conducted. On 8/4/26 at 9:25 AM, the RNC stated CNA #1 should have used hand hygiene when switching eating assistance between residents and had not.		