



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

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

FILE COPY

May 27, 2015

Darrin Radeke, Administrator
Mini-Cassia Care Center
1729 Miller Avenue, PO Box 1224
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **May 20, 2015**, a survey was conducted at Mini-Cassia Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.**

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 9, 2015**. Failure to submit an acceptable PoC by **June 9, 2015**, may result in the imposition of civil monetary penalties by **June 29, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

As noted in the Bureau of Facility Standards' letter of **May 5, 2015**, following the survey of **April 10, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **October 10, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina

Darrin Radeke, Administrator
May 27, 2015
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Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

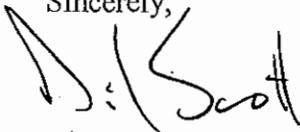
- BFS Letters (06/30/11)

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

This request must be received by **June 9, 2015**. If your request for informal dispute resolution is received after **June 9, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



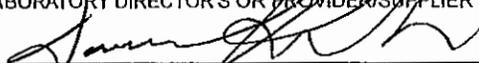
DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 05/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135081	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/20/2015
NAME OF PROVIDER OR SUPPLIER MINI-CASSIA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1729 MILLER AVENUE BURLEY, ID 83318	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiency was cited following an investigation into the facility's self-reported allegation of staff-to-resident abuse. The surveyor conducting the survey was: David Scott, RN The investigation was conducted on May 20, 2015.	F 000	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.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	F225 1. The corrective action for resident #6 is on 5/28/15 a reinvestigation showing all elements of the investigation guidance from the informational letter #2014-04 was completed. This investigation showed no abuse of the resident had taken place. 2. All residents that may be affected by abuse are potentially affected by the citation. Increased awareness of the full investigation process has been implemented and all individuals involved in the process of submitting investigations have been provided	6/8/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: ADMINISTRATOR (X6) DATE: 6/3/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1 investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on a facility self-reported incident, record review, and staff interviews, it was determined the facility failed to thoroughly investigate a resident ' s allegation that he had been abused by staff. This was true for 1 of 1 resident (#6), who was the subject of a report filed by the facility with the Idaho Department of Health and Welfare (IDHW), Bureau of Facility Standards (BFS). The facility ' s investigation into Resident #6 ' s allegation of physical abuse, as detailed in its 5/19/15 report to the (BFS), did not include:</p> <ul style="list-style-type: none"> · Evidence the facility adequately attempted to identify the accused staff member · Evidence the facility interviewed any day, evening or night shift staff members · Evidence that any other resident in the facility was interviewed · Evidence that Resident #6 or any other resident in the facility was protected from further potential abuse while the facility investigated the allegation of staff abuse <p>Additionally, the facility ' s investigative report failed to include any information either disproving the resident ' s allegation of staff abuse or supporting its own conclusion that Resident #6</p>	F 225	<p>another copy of the Informational Letter #2014-04 and educated on May 20th, 2015 on how to complete a proper investigation.</p> <p>3. A system of putting each active investigation on a board which is reviewed each work day with the a)date and time of the incident, b)what happened, c)check that all staff and other witnesses have given statements, d)check that the resident or residents involved have been interviewed, e)check that all visible injuries have been measured, f)check that, if unknown origin, 24 hours or more, if needed, prior, of all staff have been interviewed. g) check that if unwitnessed incident, determine what resident was doing when last observed by staff. h) What will be done to protect the resident(s) from further incident.</p> <p>4. The administrator will monitor that the process is being followed daily X 10, weekly X 4, then q 2 weeks x 2, then monthly. The results will be tracked on the Abuse Investigation Form and reported each month to the QAPI committee. Audits will begin on 6/4/15.</p>	

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F 225	<p>Continued From page 2</p> <p>was not physically abused by an unidentified staff member.</p> <p>This failed practice exposed residents to the potential for harm from staff members, visitors, and/or other residents who may engage in physical, emotional, verbal, sexual, and/or mental abuse, as well as involuntary seclusion, neglect, and/or misappropriation of property. Findings include:</p> <p>Federal regulatory requirement §483.13(c)(3) documented, " The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. " Idaho Department of Health and Welfare (IDHW) Informational Letter 2014-04 to all long-term care facilities in Idaho, dated 5/23/14, documented in part, " A thorough investigation is critical to developing effective prevention strategies ... some essential components of a thorough investigation include:</p> <ul style="list-style-type: none"> · All pertinent staff, resident(s), and other witnesses must be interviewed and the results of the interview documented in some form. Whenever possible, have witnesses sign a written statement. · If a staff person is accused of any [type of abuse], that person must be interviewed regarding the allegations and that interview must be documented ... The accused staff person must be suspended until the investigation is completed, in order to protect residents from further abuse. The accused staff person may not be reassigned to another department in the facility or to a sister facility. · All visible injuries must be measured and described in detail. · In cases of injury of unknown source, all staff having possible contact with the resident over the 	F 225		

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F 225	<p>Continued From page 3</p> <p>24 hours prior to injury discovery must be interviewed.</p> <p>Resident #6 was admitted to the facility 3/11/11 with diagnoses of coronary artery disease (CAD), neurogenic bladder, urinary tract infection, arthritis, chronic obstructive pulmonary disease, hemiparesis, anxiety, and dementia.</p> <p>The resident ' s most recent annual MDS assessment, dated 12/13/14, documented:</p> <ul style="list-style-type: none"> · Moderate cognitive impairment with a BIMS score of 8 · Diagnoses of depression and psychotic disorder other than schizophrenia · No dementia or hallucinations listed as active diagnoses · No physical behavior directed toward others <p>The resident ' s most recent quarterly MDS assessment, dated 3/11/15, documented:</p> <ul style="list-style-type: none"> · Severe cognitive impairment with a BIMS of 5 · Diagnoses of dementia, depression, anxiety, and psychotic disorder other than schizophrenia · Receptive to cares <p>On 5/19/15, the facility submitted a report to BFS that documented a bath aide providing a shower to Resident #6 on 5/11/15 discovered " three scratches to his upper right arm, a bruise by his right elbow, an abrasion to his right foot on the top of his instep, and a red/brown scab to his left groin/hip area, " which she reported to the on-duty nurse. When the nurse asked whether the resident knew how the injuries occurred, the report documented, " [He] told her, ' Nurse [name] threw me in bed and did it. ' " When informed the facility did not employ a nurse by the name provided by the resident, Resident #6 responded, " I can ' t help it if you don ' t know what the nurses ' names are. Her name is [name]. "</p> <p>In a section entitled, " Significant Information, "</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>the 5/19/15 report documented that the name of the nurse Resident #6 initially identified as his alleged abuser was actually the name of a former staff member who had not worked at the facility for a year, however the resident identified the location of that staff member ' s office, and stated the nurse who caused his injuries was actually a friend of the former staff member who still worked at the facility. The investigative report, completed by Resident Services Director (RSD) #11, documented, " I went on to ask him when she had thrown him in bed and he said, ' night before last. ' I asked if he could remember what she looked like. He sat for a few minutes and then he described her as the following, ' white, middle aged, average weight, light brown medium length hair, I don ' t think she has glasses. She was here night before last before midnight. ' I did name off the different nurses that do work that shift and he said ' No " to all of them. I asked if he was sure it was a nurse and maybe it was an aid instead. He continued to insist that it was [former employee ' s] friend the nurse ... he again said, ' It ' s [former employee ' s] friend and I haven ' t seen her for quite awhile (sic), she doesn ' t work here very often. "</p> <p>In a section entitled, " Recreate the Event: Summary, " the report documented, " It has been determined that the bruise on the top of his right foot is due to him self propelling his wheel chair and hitting it on the left foot pedal. The foot portion of the foot pedal was loose and did not stay locked in place ... The bruise to his right elbow was caused by him self positioning in his wheel chair and bumping it on the arm rest ... [when staff provide cares] he does take his left hand and holds onto the right arm and vice versa. His left hand does match up to where the scratches are. [Resident #6] is a smoker and the</p>	F 225		

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F 225	<p>Continued From page 5</p> <p>red/brown scab area to hip/groin area appears to be from his cigarettes ... [Resident #6] is supervised when he smokes and he also wears a smoking apron. "</p> <p>On 5/20/15 at 9:00 a.m., RSD #11, who identified herself as the staff member who conducted the facility ' s investigation into the allegation of staff abuse and was familiar with the applicable regulatory requirements, as well as BFS Informational Letter 2014-04, stated no method other than reciting a series of names to the resident was employed to identify the staff member Resident #6 accused of causing his injuries. When asked whether staff on duty the night Resident #6 said he was injured were interviewed, RSD #11 stated, " No. " When asked if any other residents in the facility were interviewed to determine whether they too may have been or knew of others who were the victims of abuse, RSD #11 stated no other residents were interviewed and she knew of no other allegations of abuse.</p> <p>When asked how the facility determined the bruises to Resident #6 ' s right foot and right elbow were self-inflicted, RSD #11 stated the resident had been observed hitting his left foot on a wheelchair pedal while self-propelling through the facility and when positioning himself while in his wheelchair. When asked how the facility determined a cigarette ash had passed through the resident ' s fire-resistant smoking apron, trousers, and adult brief to cause a burn on his groin area, RSD #11 did not answer.</p> <p>On 5/20/15 at 2:00 p.m., the facility ' s Administrator, Director of Nursing (DON), Corporate Consultant (CC), and Chief Operating Officer (COO) were interviewed. When asked whether he was familiar with regulatory requirements regarding abuse allegation</p>	F 225		

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F 225	Continued From page 6 investigations or the contents of BFS Informational Letter 2014-04, the Administrator stated, " There ' s a lot of Informational Letters. " When asked again whether he was familiar with the contents of Informational Letter 2014-04, the Administrator stated, " Oh, I ' m very familiar with it " . When asked to explain why he reviewed, approved, and signed the report of the facility ' s deficient investigation into Resident #6 ' s allegation of staff abuse, the Administrator said RSD #11 had no specialized education or training beyond her Nurse Aide certification, and stated, " I assumed those [missing components of the investigation] had been done; I had verbal encounters which led me to believe it had been done. " When asked why no staff or other residents had been interviewed in an attempt to ascertain the identity of the nurse Resident #6 said had caused his injuries, the CC stated, " We are aware we made kind of a mess of things; we are planning to do a more thorough investigation. "	F 225		