



BRAD LITTLE – Governor
DAVE JEPPESEN – Director

IDAHO DEPARTMENT OF
HEALTH & WELFARE

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 15, 2020

Lori Bentzler, Administrator
Twin Falls Transitional Care of Cascadia
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **July 2, 2020**, a survey was conducted at Twin Falls Transitional Care of Cascadia 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 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies and a directed plan of correction. 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 in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance.

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

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 27, 2020**. Failure to submit an acceptable PoC by **July 27, 2020**, may result in the imposition of penalties by **August 17, 2020**.

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

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

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved.

- 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*.

In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction is imposed on the facility.

Imposition of Denial of Payment for New Admissions (DPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning 45 days after the date the enforcement letter is sent, on **August 29, 2020**, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. Your Medicare Administrative Contractor will be notified of the date the denial of payment begins. DPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated.

Imposition of Directed Plan of Correction (DPOC):

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In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the letter, on **July 30, 2020**. The DPOC may be completed before or after that date. The effective date is not deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please send all documentation to the State Agency via ePOC.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 2, 2020**. A change in the seriousness of the deficiencies on **August 29, 2020**, may result in a change in the remedy.

We must recommend to the CMS Seattle location and/or State Medicaid Agency that your provider agreement be terminated on **January 2, 2021**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Seattle location or the State Medicaid Agency beginning on **September 30, 2020** and continue until substantial compliance is achieved.

Additionally, the CMS Seattle location or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the

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revisit, if appropriate.

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

<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 **July 27, 2020**. If your request for informal dispute resolution is received after **July 27, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in regulations at 42 CFR §498.40, et. seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than 60 days after receiving this letter.

Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

The Interim Manager, Julius Bunch; LTC Certification and Enforcement Branch; Centers for Medicare and Medicaid Services, 701 5th Ave., Suite 1600, Seattle, WA 98104 or via email: Julius.Bunch@cms.hhs.gov.

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically, or you may mail a written request for a waiver along with your written request for a hearing.

A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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Department of Health and Human Services,
Department Appeals Board,
MS 6132, Director, Civil Remedies Division, 330
Independence Ave., S.W., Cohen Building - Room G-644,
Washington, D.C. 20201,
(202) 565-9462

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

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

PRINTED: 09/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/02/2020
NAME OF PROVIDER OR SUPPLIER TWIN FALLS TRANSITIONAL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(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	
E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness survey was conducted on July 1, 2020 to July 2, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).</p> <p>The survey was conducted by:</p> <p>Presie Billington, RN, Team Leader Brad Perry, LSW</p>	E 000			

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

TITLE

(X6) DATE

Electronically Signed

07/24/2020

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

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F 000	INITIAL COMMENTS The following deficiency was cited during a COVID-19 Focused Infection Control survey conducted on July 1, 2020 to July 2, 2020. The survey was conducted by: Presie Billington, RN, Team Leader Brad Perry, LSW Survey Abbreviations: DON = Director of Nursing LPN = Licensed Practical Nurse	F 000			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		7/29/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/24/2020
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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 880	<p>Continued From page 1</p> <p>conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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F 880	<p>Continued From page 2 infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were implemented and maintained to provide a safe and sanitary environment. This failure created the potential for negative outcomes by exposing residents to the risk of infection and cross-contamination including COVID-19. Findings include:</p> <p>1. LPN #1 was observed while preparing medications in the facility's quarantine unit for newly admitted residents on 7/1/20 from 9:40 AM to 10:35 AM. LPN #1 did not follow facility policy or nursing standards of practice when preparing and administering medications. Examples include:</p> <p>a. The facility's Personal Protective Equipment (PPE) Donning policy and procedure, revised 6/25/20, directed staff to perform hand hygiene prior to donning (putting on) PPE.</p> <p>The facility had a quarantine unit for newly admitted residents. A sign was posted outside each resident's door which stated they were a recent admission and were under a precautionary quarantine for 14 days, for droplet and contact precautions. The sign also stated staff were to don a mask, eye protection, a gown, and gloves when entering the resident's room.</p>	F 880	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Transitional Care of Cascadia does not admit that the deficiencies listed on the CMS form 2567 exist nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiencies.</p> <p>F880</p> <p>Specific Residents Identified</p> <p>Resident #1 was discharged from the facility on 7/10/2020. Resident #2 was discharged from the facility on 7/23/2020. Resident #6 was discharged from the facility on 7/21/2020. Resident #7 was discharged from the facility on 7/15/2020.</p> <p>On 7/21/2020, Residents #3 and #4 were assessed by the Chief Nursing Officer for adverse effects related to the failure to follow facility policy or nursing standards</p>		

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F 880	<p>Continued From page 3</p> <p>- LPN #1 prepared Resident #1's medications for administration. After preparing the medications, LPN #1 donned a gown and gloves, locked the medication cart, and picked up the medication cup containing Resident #1's medication. LPN #1 did not perform hand hygiene before she donned her gown and gloves.</p> <p>- LPN #1 prepared the needed supplies to test Resident #2's blood sugar level. LPN #1 then donned a gown and gloves, locked the medication cart, and picked up the cups containing the supplies. LPN #1 did not perform hand hygiene before she donned her gown and gloves.</p> <p>LPN #1 came out of Resident #2's room and performed hand hygiene then took Resident #2's blister packs of medication from the medication cart. LPN #1 prepared Resident #2's medications. When she finished preparing Resident #2's medications, LPN #1 donned a gown and gloves, locked the medication cart, and carried the medication cup containing Resident #2's medication with her and entered Resident #2's room. LPN #1 did not perform hand hygiene before she donned her gown and gloves.</p> <p>- LPN #1 performed hand hygiene and took Resident #3's blister packs of medication from the medication cart. LPN #1 then prepared Resident #3's medications. When LPN #1 finished preparing Resident #3's medications she donned a gown and gloves, locked the medication cart, and picked up the medication cup containing Resident #3's medications and entered Resident #3's room. LPN #1 did not perform hand hygiene before she donned her gown and gloves.</p>	F 880	<p>of practice when preparing and administering medications including failure to perform hand hygiene during medication pass. No adverse effects noted.</p> <p>On 7/21/2020, Resident #5 was assessed by the Chief Nursing Officer for adverse effects related to the failure to follow facility policies for cleaning and disinfecting and standard precautions including the wearing of gloves while touching chemicals, failure to perform hand hygiene and failure to disinfect surfaces properly. No adverse effects noted.</p> <p>Identification of Other Residents</p> <p>On or before 7/29/2020, other facility residents will be assessed by the Chief Nursing Officer or designee for adverse effects or signs and symptoms of infection related to the failure to follow facility policy or nursing standards of practice when preparing and administering medications including the failure to perform hand hygiene during medication pass. Residents identified to have signs or symptoms of infection will be reported to the physician and findings will be addressed as ordered.</p> <p>On or before 7/29/2020, licensed nurses will be observed by the Chief Nursing Officer or designee during medication pass to ensure that they are following facility policy and nursing standards of practice. Any identified issues will be</p>		

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F 880	<p>Continued From page 4</p> <p>- LPN #1 performed hand hygiene and took Resident #4's blister packs of medication from the medication cart. When LPN #1 finished preparing Resident #4's medications, she donned a gown and gloves, locked the medication cart, and took the medication cup containing Resident #4's medications and entered Resident #4's room. LPN #1 did not perform hand hygiene before she donned her gown and gloves.</p> <p>On 7/1/20 at 11:06 AM, LPN #1 said she performed hand hygiene before she prepared the residents' medications but said she did not perform hand hygiene before she donned the gown and gloves. LPN #1 said she should have performed hand hygiene before donning her gown and gloves.</p> <p>On 7/1/20 at 2:00 PM, the DON, together with the Infection Control Preventionist (ICP) and Clinical Resource Nurse, said hand hygiene should be performed by staff before donning PPE.</p> <p>b. According to Potter & Perry's Fundamentals of Nursing Practice, eighth edition, when administering oral medications they should not be touched by fingers to avoid contamination of medication and waste.</p> <p>LPN #1 was observed preparing medications for administration to Resident #3. She performed hand hygiene and took Resident #3's blister packs of medication from the medication cart. She pressed on each of the blister packs of medication to push the pill into the medication cup. The first three pills fell onto LPN #1's bare hand rather than in the medication cup. LPN #1 then put the pills into the medication cup. When</p>	F 880	<p>immediately addressed.</p> <p>On or before 7/29/2020, Housekeeping Staff will be observed by the facility Infection Preventionist or designee to ensure that they are following the facility policies for cleaning and disinfecting, hand hygiene and use of PPE. Any identified issues will be immediately addressed.</p> <p>Systemic Changes</p> <p>On 7/20/2020, a root cause analysis was completed by facility staff. Recommendations implemented and training will be completed by the Chief Nursing Officer and/or Infection Preventionist on or before 7/29/2020.</p> <p>On or before 7/29/2020, the Chief Nursing Officer and/or Infection Preventionist will complete training of licensed nursing staff and housekeeping staff regarding the use of PPE, hand hygiene and the need and importance of contact time for EPA approved cleaners.</p> <p>Monitoring</p> <p>Beginning on 7/30/2020, the Infection Preventionist or designee will audit medication pass to ensure that nurses follow facility policies and nursing standards of practice regarding infection control. Audits will be completed on each shift daily for three weeks and then completed with four licensed nurses weekly for 4 weeks and then two licensed</p>		

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F 880	<p>Continued From page 5</p> <p>LPN #1 finished preparing Resident #3's medications she donned a gown and gloves, locked the medication cart, and picked up the medication cup containing Resident #3's medications. LPN #1 entered Resident #3's room and administered the medications.</p> <p>LPN #1 came out of Resident #3's room, performed hand hygiene and took Resident #4's blister packs of medication from the medication cart. She then pressed the blister packs of medication to push the pills into the medication cup. The first two pills fell onto LPN #1's bare hand. LPN #1 then put the pills into the medication cup. When LPN #1 finished preparing Resident #4's medications, she donned a gown and gloves, locked the medication cart, and took the medication cup containing Resident #4's medications. LPN #1 entered Resident #4's room and administered the medications.</p> <p>On 7/1/20 at 11:06 AM, LPN #1 said she was not supposed to touch the pills with her bare hands. LPN #1 said the pills should have been discarded.</p> <p>On 7/1/20 at 2:00 PM, the DON, together with the ICP and Clinical Resource Nurse, said residents' medications should not be touched with the nurse's bare hand.</p> <p>2. The facility's Cleaning and Disinfecting policy, dated 7/24/18, directed staff to wear gloves to avoid skin reactions and exposure to harmful chemicals.</p> <p>The facility's Standard Precautions policy, dated 11/15/19, directed staff to wear gloves when potential exposure to bodily fluids was anticipated</p>	F 880	<p>nurses monthly for 2 months.</p> <p>Beginning on 7/30/2020, the Infection Preventionist or designee will audit housekeeping staff to ensure that facility policies are followed for cleaning and disinfecting and standard precautions. Audits will be completed on each shift daily for three weeks, then completed with three housekeepers weekly for 4 weeks, and then two housekeepers monthly for 2 months.</p> <p>Any concerns identified will be addressed immediately.</p> <p>Results of the audits will be reported to the QAPI committee monthly for 3 months for review and remedial interventions. The Chief Nursing Officer is responsible for monitoring and compliance. The QAPI committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 880	<p>Continued From page 6</p> <p>and to change gloves and perform hand hygiene after contact with residents' environment and between tasks.</p> <p>These policies were not followed.</p> <p>a. On 7/1/20 from 11:01 AM to 11:53 AM, Housekeeper #1 was observed cleaning two resident rooms in the 100 hall and two resident rooms in the facility's quarantine unit.</p> <p>At 11:01 AM, Housekeeper #1 was in the hallway outside of Resident #6's room and was wearing a surgical mask and goggles. Her cleaning cart had several Velcro type mop cleaning pads in a mop bucket with a quaternary (an ammonium compound) disinfectant and cleaning solution. Housekeeper #1 wrung out a mop pad with her bare hands and mopped Resident #6's room and bathroom floors. She then took off the mop pad with her bare hands and placed it in a dirty linen bag on her cart. Housekeeper #1 did not perform hand hygiene. Housekeeper #1 then went to the 100 hall biohazard room and brought out two wet floor signs with her bare hands and placed one at the entrance to Resident #6's room and one near the door of Resident #7's room. She then moved her cleaning cart outside of Resident #7's room and donned gloves. Housekeeper #1 did not perform hand hygiene after cleaning Resident #6's room and she did not perform hand hygiene before donning gloves.</p> <p>Housekeeper #1 used a key to open a locked compartment of the cart and retrieved a toilet bowl cleaner and a toilet brush caddy. She went into Resident #7's bathroom and could be heard cleaning. As she exited the bathroom she had a plastic trash bag with trash in it and disposed of it</p>	F 880			

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F 880	<p>Continued From page 7</p> <p>in the trash compartment of the cart and replaced the toilet bowl cleaner and caddy into the cart. Housekeeper #1 then doffed (took off) her right glove and donned a new glove to her right hand without performing hand hygiene. She then took a clean rag and dipped it in a container with bleach solution on the cart. Housekeeper #1 took the rag into Resident #7's room and wiped down the counter and sink, then disposed of the rag in the dirty linen bag on the cart. She took a broom and a long-handled dustpan and swept the floor of Resident #7's room. After sweeping the floor she doffed both gloves. Housekeeper #1 did not perform hand hygiene. Housekeeper #1 then used her bare hands and wrung out a new mop pad from the mop bucket, mopped Resident #7's room and bathroom floors, and placed the mop pad in the dirty linen bag. Housekeeper #1 did not perform hand hygiene.</p> <p>At 11:15 AM, Housekeeper #1 moved her cart in front of Resident #2's door which was in the facility's quarantine unit. Signs outside the door directed staff to don a gown and gloves before entering the room, which had PPE placed outside the door for staff. She retrieved a gown out of a drawer and donned the gown and gloves. Housekeeper #1 did not perform hand hygiene prior to donning the gown and gloves. She then went into Resident #2's room, collected and disposed of two bags of trash into the cart, and flushed the toilet. Without removing her gloves, Housekeeper #1 then unlocked a compartment of the cart and retrieved the toilet bowl cleaner and the toilet brush caddy. Using the same gloves, she then took a clean rag and dipped it in the container with bleach solution. She took the rag with the toilet bowl cleaner and caddy and could be heard cleaning in Resident #2's bathroom.</p>	F 880			

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F 880	<p>Continued From page 8</p> <p>Housekeeper #1 came back out to the cart and placed the rag into the dirty linen bag and replaced the toilet bowl cleaner and caddy into the cart. Using the same gloves, she then took a clean rag and dipped it the container of bleach solution and went back into Resident #2's room and wiped down the bedside table, counter, and sink and then placed the rag in the dirty linen bag. She then doffed her gloves. Housekeeper #1 did not perform hand hygiene after removing her gloves. Then with her bare hands, Housekeeper #1 went back into the room, replaced Resident #2's trash can liner, and dry mopped and swept the room and bathroom floors. Housekeeper #1 then used the broom and dustpan and swept up debris from the floor. She then used her bare hands and wrung out a new mop pad from the mop bucket and mopped Resident #2's room and bathroom floors. She then donned a glove to her right hand, without performing hand hygiene, and removed the mop pad with the gloved hand and placed it into the dirty linen bag. She then doffed the glove to her right hand, doffed her gown, and performed hand hygiene.</p> <p>At 11:35 AM, Housekeeper #1 retrieved the wet floor signs from Resident #6 and Resident #7's room doorways and placed them at the doorway of Resident #1 and Resident #2's rooms. Resident #1's room was also in the quarantine unit and signs outside the door directed staff to don a gown and gloves before entering the room. She retrieved a gown from the PPE supplies next to Resident #2's room door and donned the gown. Housekeeper #1 then went into the CNA supply closet next to the room and retrieved a box of gloves and donned new gloves. Housekeeper #1 then unlocked the compartment of the cart and retrieved the toilet bowl cleaner</p>	F 880			

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F 880	<p>Continued From page 9</p> <p>and the toilet brush caddy. She then took a clean rag and dipped it in the container with bleach solution, using the same gloves. She took the rag with the toilet bowl cleaner and caddy and could be heard cleaning Resident #1's bathroom. Housekeeper #1 disposed of the rag into the dirty linen bag and placed the toilet bowl cleaner and caddy into the cart. She did not doff her gloves or perform hand hygiene. Housekeeper #1 then took a clean rag and dipped it the container of bleach solution, using the same gloves, and wiped down Resident #1's counter, sink, and door handle and then disposed of the rag in the dirty linen bag. She then collected the trash from Resident #1's room and doffed her gloves without performing hand hygiene after. Then with her bare hands, Housekeeper #1 went back into the room, replaced Resident #1's trash can liner, dry mopped and swept the room and bathroom floors and used the broom and dustpan and swept up debris from the floor.</p> <p>At 11:48 AM, Housekeeper #1 used her bare hands and wrung out a new mop pad from the mop bucket as Laundry Aide #1 walked by and told Housekeeper #1 to use gloves when she did that. Housekeeper #1 then donned gloves without performing hand hygiene and re-wrung the mop pad. She then mopped Resident #1's room and bathroom floors, removed the mop pad and placed it into the dirty linen bag. Housekeeper #1 then doffed her gloves without performing hand hygiene and with her bare hands used the broom and dustpan and swept up debris from the floor near the doorway entrance. Housekeeper #1 then performed hand hygiene.</p> <p>On 7/1/20 at 11:54 AM, Housekeeper #1 said she did not perform hand hygiene after removing her</p>	F 880			

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F 880	<p>Continued From page 10</p> <p>gloves each time and she said she should have used hand sanitizer. She said she was supposed to wear gloves in the rooms in the quarantine area and did not.</p> <p>On 7/1/20 at 2:00 PM, the DON said she expected housekeeping staff to wear gloves when handling chemicals and when in the quarantine unit rooms. The DON said Housekeeper #1 had multiple breaches of infection control practices and did not perform hand hygiene when it was expected.</p> <p>b. On 7/1/20 at 12:12 PM, Housekeeper #2 sprayed Resident #5's sink countertop and sanitizer dispenser that was mounted on the wall near the sink with Clorox Bleach Germicidal Cleaner. She immediately wiped the sink countertop and the sanitary dispenser with a cloth. Housekeeper #2 went back to her cleaning cart, removed her gloves and pushed her cart out of the hall. She did not perform hand hygiene after removing her gloves.</p> <p>On 7/1/20 at 12:18 PM, Housekeeper #2 said she did not perform hand hygiene after she removed her gloves because her gloves were not soiled. Housekeeper #2 said she was not aware she needed to perform hand hygiene after removing gloves.</p> <p>On 7/1/20 at 2:00 PM, the DON said the facility's hand hygiene policy applied to all staff. The DON said Housekeeper #2 should have performed hand hygiene after removing her gloves.</p> <p>3. The Clorox Bleach Germicidal Cleaner directions for cleaning and disinfecting nonporous surfaces was to spray 6 to 8 inches from the</p>	F 880			

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F 880	<p>Continued From page 11</p> <p>surface until the surface is thoroughly wet and allow this product to remain wet for one minute.</p> <p>This direction was not followed.</p> <p>On 7/1/20 at 12:12 PM, Housekeeper #2 sprayed Resident #5's sink countertop and sanitizer dispenser that was mounted on the wall near the sink with Clorox Bleach Germicidal Cleaner. She immediately wiped the sink countertop and the sanitary dispenser with a cloth. Housekeeper #2 went back to her cleaning cart, removed her gloves and pushed her cart out of the hall. Housekeeper #2 did not follow the manufacturer instructions for disinfection and allow the surfaces to remain thoroughly wet for one minute.</p> <p>On 7/1/20 at 12:18 PM, Housekeeper #2 said she knew the Clorox Bleach Germicidal Cleaner required a one-minute contact time. Housekeeper #2 said she wiped Resident #5's sink countertop and sanitary dispenser after she sprayed them with the Clorox Bleach Germicidal Cleaner because she knew the food cart was coming. Housekeeper #2 said she wanted her cleaning cart to be out of the way when the food cart arrived.</p> <p>On 7/1/20 at 2:00 PM, the ICP together with the DON and Clinical Resource Nurse, said the manufacturer instructions for using the Clorox Bleach Germicidal Cleaner should have been followed.</p>	F 880			