

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Seattle Division of Survey & Certification
Survey & Operations Group-CMS Seattle
701 Fifth Avenue, Suite 1600
Seattle, WA 98104



September 30, 2020

Administrator
Creekside Transitional Care And Rehabilitation
1351 West Pine Avenue
Meridian, ID 83642-5031

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Re: CMS Certification Number: 135125
Focused Infection Control Survey 08/18/2020
Imposition of Remedies

Dear Administrator:

The Secretary of the U.S. Department of Health & Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare, and rights of Medicare and Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to the Centers for Medicare & Medicaid Services (CMS).

On August 18, 2020, CMS completed a Focused Infection Control survey at Creekside Transitional Care And Rehabilitation to determine if the facility was in substantial compliance with the Federal requirements for nursing homes participating in the Medicare and/or Medicaid programs. After careful review of the findings from this survey, CMS has determined that Creekside Transitional Care And Rehabilitation was no longer in substantial compliance with the requirements for participation as a provider of services in the Medicare program established under Title XVIII and XIX of the Social Security Act (the Act).

You were informed by the State Agency that the surveyors found a situation(s) of Immediate Jeopardy and/or Substandard Quality of Care (SQC). Surveyors found a situation of immediate jeopardy to patient health and safety that lasted thirteen (13) days, beginning August 12, 2020 with a last day of August 24, 2020. Although the conditions that represented Immediate Jeopardy had been removed, the facility continues not to be in substantial compliance with Federal requirements as a result of uncorrected deficiencies.

The results of this survey was listed on the Statement of Deficiencies (Form CMS-2567) and sent to you. The most serious health deficiency(ies) during the survey(s) was/were the deficiency(ies) found at: Survey Tag – Scope and Severity – 42 C.F.R. section:

I. REMEDIES

Based upon this finding of noncompliance, CMS has determined, in accordance with Sections 1819(h) and 1919(h) of the Social Security Act and the enforcement regulations at 42 C.F.R. Part § 488, including 42 C.F.R. §§ 488.402 and 488.406, to impose the following remedies:

1. Termination of Medicare Provider Agreement if Substantial Compliance is Not Achieved:

- Unless your facility achieves substantial compliance before **February 18, 2021**, CMS will terminate your facility's Medicare Provider Agreement in accordance with the statutory provisions at §1819(h)(2)(C) and §1919(h)(3)(D) and Federal regulations at 42 C.F.R. §488.12 and §488.456. In accordance with 42 C.F.R. 489.53(d), CMS will publish legal notice of your pending termination action on the CMS website fifteen (15) days prior to the effective termination date.

2. Denial of Payment for New Admissions (DPNA):

- Payment will be denied for all NEW Medicare and Medicaid admissions, beginning **October 15, 2020** in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 C.F.R. § 488.417. CMS will notify your Medicare payer of the date the denial of payment begins. The DPNA will continue until the day before your facility achieves substantial compliance, or your provider agreement is terminated.

3. Civil Money Penalty (CMP):

In accordance with Sections 1819(h)(2)(B)(ii) and 1919(h)(3)(C)(ii) of the Social Security Act and the enforcement regulations specified at 42 C.F.R. Part 488, we are imposing the following CMP:

- **Federal Civil Money Penalty of \$8,995.00 per day for the twelve (12) days beginning August 12, 2020 and continuing through August 23, 2020 for a total of \$107,940.00.**
- **Federal Civil Money Penalty of \$540.00 per day beginning August 24, 2020 and continues** until you have made the necessary corrections to achieve substantial compliance with the participation requirements, or your provider agreement is terminated. Please note, the amount of the CMP may be increased or decreased if CMS finds that the level of noncompliance changes. CMS will send Creekside Transitional Care And Rehabilitation notification of any further enforcement actions as they occur.

4. Directed Plan of Correction (DPOC):

In accordance with Federal regulations at 42 C.F.R. § 488.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 C.F.R. § 488.402(f), this remedy is effective fifteen (15) calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not deadline for completion of the DPOC. However, CMS 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 note, if documentation includes any resident Personal Identifiable Information (PII) or Personal

Health Information (PHI) it must be sent encrypted.

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies, within ten (10) days (by **October 12, 2020**) after receipt of the Form CMS-2567. Please see the attached instructions (DPOC attachment) for detailed guidance.

These remedies will continue in effect until the termination effective date of your Medicare Provider Agreement, or the facility is found back in substantial compliance.

Please send all documentation to Ellen Jung, Health Insurance Specialist, via e-mail at Ellen.Jung@cms.hhs.gov and via fax at (443) 380-5035.

II. FINANCIAL HARDSHIP

In determining the amount of the CMP, CMS has considered factors that included, but were not limited to, the following: the nature of the deficiencies, the facility's history of noncompliance (including repeated deficiencies), the extent to which the deficiencies were directly related to a failure to provide quality patient care, indications of system-wide failures to provide quality care, the size of the agency, and the financial condition of the facility to the extent CMS is aware of it. If you have specific financial information you want CMS to consider, please submit it to us within ten (10) calendar days from the date of this letter. For example, such information should include, but is not limited to, the following:

- The facility's year-to-date financial statements (including profit and loss statement and balance sheet). If possible, this information should be audited or certified;
- The facility's audited financial statements from the previous year, complete with all attachments and audit notes;
- The facility's current year cash flow projections, with year-to-date actual; and
- The facility's signed federal tax return from the previous year.

III. INFORMAL DISPUTE RESOLUTION (IDR) AND INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR) RIGHTS

A. INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with the regulation at 42 C.F.R. § 488.331(a)(2), providers have one opportunity to informally refute deficiencies cited at a Focused Infection Control Survey through the Informal Dispute Resolution (IDR) process.

To request an IDR, please fax and e-mail your request identifying the specific deficiency(ies) being disputed, along with an explanation of why you are disputing them and all supporting documentation, to Seattle_LTC@cms.hhs.gov, Attn: Julius Bunch.

Please note, e-mail requests for IDR that include any resident Personal Identifiable Information (PII) or Personal Health Information (PHI) must be sent encrypted.

An IDR may be used to dispute survey findings, but it cannot be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting Immediate Jeopardy and Substandard Quality of Care (SQC);
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR and materials within ten (10) calendar days from the receipt of this notice. CMS will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies (Form CMS-2567), CMS will send you a revised Form CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for Informal Dispute Resolution, so that CMS may also have counsel present.

B. INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 C.F.R. § 488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process (IIDR). You may also contest Scope and Severity assessments for deficiencies which resulted in a finding of Immediate Jeopardy and/or Substandard Quality of Care (SQC).

To request an IIDR, please fax and e-mail your request in addition to supporting documents, including the specific deficiency(ies) being disputed and an explanation of why you are disputing those deficiency(ies), to Seattle_LTC@cms.hhs.gov, Attn: Julius Bunch.

In addition, all supporting documents must also be faxed or mailed directly to the following:

Christina Compher
Healthcare Management Solutions, LLC
1000 Technology Drive, Suite 1310
Fairmont, WV 26554
Direct Line: (615) 967-1169
Fax: (304) 368-0389

Please note, e-mail requests for IIDR that include any resident Personal Identifiable Information (PII) or Personal Health Information (PHI) must be sent encrypted.

This request must be sent in writing within ten (10) calendar days of receipt of this notice. An incomplete IIDR process will not delay the effective date of any enforcement action.

Please be advised that you are not required to request an IIDR. You may not use both dispute resolution processes at § 488.331 and § 488.431 for the same deficiency citation arising from the same survey, unless the IDR was completed prior to CMS imposing the civil money penalty. The IIDR

process is not a formal evidentiary hearing, and does not grant further appeal rights.

IV. WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of Nurse Aide Training And Competency Evaluation Programs (NATCEP) and Nurse Aide Competency Evaluation Programs (NACEP) offered by, or in, a facility which, within the previous two (2) years, if one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of Substandard Quality of Care;
- Has been assessed a total civil money penalty of not less than \$11,160;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or;
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

In light of the foregoing, you may finish any nurse assistant training class you are presently conducting; you may not, however, start another such class.

V. APPEAL RIGHTS

If you disagree with the determination of noncompliance for the August 18, 2020 survey, you or your legal representative may request a hearing before an Administrative Law Judge (ALJ) of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set forth in 42 C.F.R. § 498.40, et. seq. You may appeal the finding(s) of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of facts and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing at your own expense.

Requests for a hearing submitted by U.S. Mail or commercial carrier are no longer accepted, unless you do not have access to a computer or internet service. 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 sixty (60) calendar days from the date indicated on this notice. See 42 C.F.R. § 498.40(a)(2).

The DAB Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59 P.M. Eastern Time will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS, or that the CRD issues on behalf of the ALJ, via DAB E-File. Further instructions are located at: https://dab.efile.hhs.gov/appeals/to_crd_instructions. Please contact the CRD at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB

E-Filing System, please contact the E-File System Support at OSDABImmediateOffice@cms.hhs.gov, or call (202) 565-0146 before 4:00 P.M. Eastern Time.

VI. CMP REDUCTION FOR WAIVER OF APPEAL RIGHTS

In lieu of requesting a hearing to challenge the finding(s) of noncompliance noticed herein, you may choose to waive your right to such a hearing. **A decision to exercise this waiver option must be made in writing within sixty (60) calendar days from the date of this notice. See 42 C.F.R. § 488.436.**

To receive this reduction, please send a written waiver to Seattle_LTC@cms.hhs.gov, Attention: Ellen Jung. Please include your CCN and the Cycle Start Date in the subject line of your email.

Such a waiver of your hearing rights would constitute an acceptance of this office's determination that your facility was not in substantial compliance as documented during the August 18, 2020 survey, and an acceptance of all enforcement remedies under 42 C.F.R. § 488.406 resulting from the finding(s) of noncompliance not being challenged. By your waiver, therefore, you would accept all of the enforcement remedies that are being imposed by this office as a result of our determination that your facility was not in substantial compliance with 42 C.F.R. Part 483 participation requirements as documented during the August 18, 2020 survey. The total amount of the affected CMP, however, would be reduced by thirty-five percent (35%) in accordance with 42 C.F.R. § 488.436(b). **The failure to request a hearing within sixty (60) calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

Please direct any questions or correspondence related to this matter to CMS in the care of Ellen Jung, Health Insurance Specialist, via e-mail, at Seattle_LTC@cms.hhs.gov, Attention: Ellen Jung.

Sincerely,

Julius P. Bunch, Jr.
Branch Manager
Seattle Long Term Care
Survey & Enforcement Division
Survey & Operations Group

Copies sent via e-mail sent to:

Bureau Of Facility Standards
State Medicaid Agency
Office of the General Counsel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2020
NAME OF PROVIDER OR SUPPLIER CREEKSIDE TRANSITIONAL CARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
(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	<p>INITIAL COMMENTS</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) onsite August 12, 2020 and August 13, 2020 at Creekside Transitional Care and Rehabilitation with remote review of records concluded on August 18, 2020.</p> <p>The facility was not in substantial compliance with 42 CFR §483.80 infection prevention and control and the facility did not fully implement CMS and Centers for Disease Control and Prevention (CDC) guidelines and recommended practices to prepare for COVID-19.</p> <p>The facility failed to implement and maintain infection control measures to prevent facility-transmission of COVID-19. Deficient infection control practices related to separation and staffing of the resident care units with suspected or known COVID-19 infection, maintenance of transmission-based precautions, use of PPE, hand hygiene, and social distancing placed all COVID negative residents and staff in the facility at risk for exposure to and potential for serious illness and death from COVID-19 infection which constituted immediate jeopardy.</p> <p>On 8/12/2020 at 2:00 PM and on 8/13/20 at 4:00 PM the facility administrator was notified in person and written notice by email on 8/13/20 of the determination of immediate jeopardy at 42 CFR §483.80 F880 infection prevention and control.</p> <p>The immediate jeopardy was ongoing at the conclusion of the onsite survey on 8/13/20.</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/25/2020

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	Continued From page 1 Facility Resident Census 106. Resident sample 18. Federal surveyors can be reached at: Department of Health and Human Services Centers for Medicare and Medicaid Services 701 Fifth Avenue Suite 1600 Mailstop 400 Seattle, WA 98104 206.615.2313	F 000			
F 880 SS=K	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 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		9/26/20	

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F 880	<p>Continued From page 2 but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <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 infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880			

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F 880	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of policies, and record review the facility failed to implement and maintain an effective infection control program to contain and prevent facility transmission of COVID-19 in accordance with Centers for Disease Prevention and Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines and requirements.</p> <p>The facility failed to ensure infection control standards related to resident and staff hand hygiene and use of personal protective equipment were implemented and maintained for randomly observed residents on the 100, 200, and 300 halls. The facility failed to ensure dental staff while providing services in the facility and family members during a compassionate visit used appropriate PPE and practiced social distancing.</p> <p>The facility failed to ensure staff donned, doffed, and used PPE (personal protective equipment) in accordance with accepted standards of practice to prevent contamination of PPE intended for reuse when caring for R1 who had COVID-19.</p> <p>The facility failed to ensure staff used all recommended PPE in accordance with CDC guidelines for new and readmitted residents to prevent facility-transmission of COVID-19. The facility failed to implement appropriate transmission-based precautions during the 14-day period following admission for R10 and R 16.</p> <p>On 8/12/20 the facility was made aware 5 of 25 residents on the 100 hall (R1, R4, R5, R6, and</p>	F 880	<p>Immediate corrective action for residents found to have been affected by deficient practice:</p> <p>R10 tested positive for COVID19 and was moved to the COVID unit.</p> <p>R2 has been discharge from the facility</p> <p>Residents exposed to dental services employee [P1] have had COVID-19 testing and results were negative. Appropriate monitoring is in place for these residents.</p> <p>IV bag for R2 was removed 8/12/2020 by IP.</p> <p>Medical Director was immediately notified.</p> <p>Unit Manager was immediately educated on donning and doffing isolation PPE, hand washing procedures, and isolation procedures. (Completed 8/13/20). All staff will be re-in-service and demonstrate competency on donning and doffing isolation PPE, hand washing procedures, and isolation procedures prior to their next assigned shift.</p> <p>COVID positive residents were transferred to the COVID positive unit.</p> <p>100 Hall residents are people under investigation for COVID and 100 hall separated physically from the remainder of the facility by utilizing the fire doors in</p>		

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F 880	<p>Continued From page 4</p> <p>R10) tested positive for COVID-19. Although the facility moved the five residents to the COVID unit; the facility failed to identify the 20 remaining 100 hall residents and 100 hall assigned or float staff as persons under investigation for COVID-19. The facility failed to implement use of full PPE for care of all residents on the 100 hall, failed to implement immediate separation of the 100 hall from the rest of the building and failed to ensure dedicated staff to contain COVID-19 to the affected unit (100 hall) and prevent spread to other areas of the facility. Two days later 10 additional COVID positive residents were identified on the 100 hall.</p> <p>The facility failed to implement a system to ensure accurate and timely identification of residents and staff exposed to COVID-19, with unknown COVID status, and with positive COVID-19 status. Accurate and timely information is necessary to ensure implementation of transmission-based pre-cautions, isolation of staff and residents, cohorting of residents, and assignment of staff.</p> <p>The facility failure to maintain infection control measures to prevent facility-transmission of COVID-19 placed staff and 96 residents on the non-COVID units in immediate jeopardy and at risk for serious illness and death related to COVID-19. Immediate action was required to prevent further spread of COVID-19 to other areas of the facility.</p> <p>The facility administrator was informed of the determination of immediate jeopardy verbally on 8/12/20 at 2:00 PM, verbally on 8/13/20 at 4:00 PM, and in writing by email on 8/13/20.</p>	F 880	<p>the closed position. No entry from facility to the 100 hall through these doors with the exception of clean linen/supply cart and food trays. When those items are delivered to fire doors, only cart and items will pass through doors, not staff. After 100 hall has retrieved items from cart, the cart will be pushed out the outside facility exit at the end of 100 hall and disinfected prior to being picked up to return to kitchen or place of origin. All staff will enter and exit through the outside facility door at the end of 100 hall. (Implemented 8/13/20).</p> <p>Dedicated staff were assigned to work on the 100 hall and will adhere to all PPE for the investigation period. Staff working the 100 hall will not be assigned to work other halls. (Implemented 8/13/20).</p> <p>100 hall PPE will include mask, eye protection, gown, and gloves for the duration of the investigation period. The investigation period will be 14 days from last exposure. Residents will continue to be tested for COVID and if additional residents on the 100 hall become positive, the investigation period will be extended accordingly. (Implemented 8/13/20).</p> <p>Q shift monitoring for signs of symptoms of COVID for 100 hall residents who are PUI.</p> <p>Effective 8/19/20 the COVID unit manager was removed from her position and a new Unit Manager was put in place to oversee the COVID unit.</p>		

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F 880	<p>Continued From page 5</p> <p>Findings include:</p> <p>The facility administrator and the facility Infection Control Officer (IP, infection preventionist) were interviewed on 8/12/20 at 9:30 AM. The administrator reported a resident census of 106. IP said the facility had a dedicated COVID unit (700 hall). The COVID unit was self-sustaining with a separate entrance and exit, dedicated staff who worked only on the COVID unit and did their own housekeeping with meals delivered to the unit in disposable plates and utensils. IP reported the current census on the COVID unit was 10 and the facility staffed for 10 but could staff for a surge on the COVID unit. IP said the staff on the COVID unit used full PPE including washable gowns. The administrator reported the facility had adequate PPE and expected a delivery of N95 masks that day.</p> <p>IP said the 500 hall was designated for new admissions and readmissions for 14-day observation/quarantine before moving to other units in the facility. IP described the 400 hall as the "step-down" unit for residents under investigation for COVID and for residents who come out of the COVID unit to allow for an additional two weeks observation. IP said one resident, (R1) was in isolation at the end of the 400 hall because he was symptomatic and waiting for COVID test results.</p> <p>IP said the facility was open to visitors for a short time and had a "fair amount of visitors" but was again closed to visitors due to some positive COVID tests. IP said all residents were tested on admission and placed on isolation for 14 days. The facility conducted universal testing (testing all including those with no signs or symptoms of</p>	F 880	<p>All staff on shift 8/19/20 were immediately trained by a clinical member of the governing body and Infection Prevention Resource on updated policy and procedures as outlined below. All subsequent staff will be trained by governing body, Infection Prevention Clinical Resource, Infection Preventionist or Unit Manager prior to working COVID unit on the updated policy and procedures listed below:</p> <p>The procedure for Staff Screening was updated.</p> <p>Screening station was located in the green zone outside of COVID unit.</p> <p>Anyone entering the COVID unit will be actively screened prior to entering. Staff were trained prior to their next oncoming shift to not enter the COVID unit until they are actively screened and cleared to work.</p> <p>A phone was provided outside of the unit at the screening station for anyone attempting to enter the unit. Instructions will be provided with a phone number to call to be screened prior to entry. The policy/procedure for N95 Use was updated for the COVID unit.</p> <p>At the beginning of every shift staff don a new N95 mask. Employee do not use N95 mask for more than one shift.</p> <p>At the end of the shift staff place their</p>		

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F 880	<p>Continued From page 6</p> <p>COVID) for staff and residents. IP said in July 2020; five staff tested positive for COVID-19 and were from different units.</p> <p>Documentation of facility surveillance and tracking of persons under investigation for COVID-19 such as persons with symptoms, known exposure, and new admissions, was requested. IP provided a spreadsheet that showed universal COVID testing of residents on 6/26/20 with no positive results and testing on 7/23/20 with COVID positive results identified for two residents on the 400 hall.</p> <p>When asked for all information regarding infection surveillance, IP provided a spreadsheet titled Admit Cohort Tracking Log. The log had seven columns: resident name, admit to, admit date, 1st test, results, 2nd test, results, and OFF ISO. The log included 28 resident names admitted to rooms on the 500 and 700 halls. The log covered dates from 5/11/20 through 6/30/20. IP said he was behind in updating the infection surveillance logs.</p> <p>IP provided a third spreadsheet titled, COVID Unit. The log had seven columns; name, positive test date, moved to unit, symptoms onset, symptoms, clear date, and discharged to. Fourteen resident names were entered. The log indicated R11 with a positive test date of 7/31/20 admitted to the unit on 8/5/20 with symptom onset 8/11/20 of shortness of breath and pulmonary symptoms. The clear date column indicated; continue to monitor if improved reeval [reevaluate] on 8/21/20.</p> <p>In an interview on 8/13/20 at 10:20 AM, IP said the facility moved the COVID unit from the 400 hall to the 700 hall around July 22, 2020 "so the</p>	F 880	<p>used N95 mask in the used N95 mask container upon exiting the unit.</p> <p>Updated Face Shield procedure for COVID unit.</p> <p>Each staff should have their own face shield (do not share face shields.</p> <p>Prior to donning at the beginning of a shift, staff disinfect your face shield with EPA registered disinfectant. Disinfect the inside and then the outside</p> <p>Upon exiting unit for break or end of day, staff disinfect the face shield inside and then outside with registered EPA disinfectant.</p> <p>Face Shields should be stored in individual bins after cleaning.</p> <p>Personal Items- Personal items should be stored in the green area and not on the unit.</p> <p>Housekeeping- COVID checklist and daily and terminal cleaning checklist added to policy and procedures and used to train staff and guide staff in housekeeping. Additional housekeeping equipment was purchased for use in the COVID unit. Housekeeping supervisor completed a train the trainer with Unit Manger and Infection Preventionist on housekeeping policy and procedures. Subsequently unit manager and infection preventionist trained all staff on the COVID unit on housekeeping policy and procedures. All appropriate cleaning solutions were</p>		

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F 880	<p>Continued From page 7</p> <p>dates on the log may be skewed." When asked about the log entry for R11 with positive test on 7/31/20 and not moved to COVID unit until 8/5/20, IP said it probably took that long to get the test results back. When asked if R11 was in isolation while waiting test results, IP replied "Probably so" but IP said he did not include residents under investigation or waiting for test results and did not include staff in his surveillance data.</p> <p>IP said he recently passed his RN boards and although he completed the CDC course for infection control he was new to his role as infection control officer (infection preventionist) and did not yet have a coordinated and comprehensive system set up to document tracking and trending for surveillance during infection outbreaks such as COVID-19. IP said the facility based policies and procedures on CDC guidelines and he was not aware of tools available through CDC to assist LTC facilities to detect, characterize, and investigate outbreaks of respiratory illness such as COVID-19.</p> <p>A separate universal testing spreadsheet showed staff testing 6/26/20 identified two licensed nurses and one central supply staff who tested positive. Staff testing between 7/8/20 and 7/27/20 indicated two licensed nurses, two nursing assistants, and one physical therapist tested positive for COVID-19. The staff test spreadsheet did not indicate where the staff worked in the building, did not indicate if known exposure or presence or absence of COVID-19 symptoms, and did not indicate interventions or disposition. IP said the COVID positive staff worked on all units including the 100 hall.</p>	F 880	<p>identified and placed on the hall. All inappropriate cleaning products were removed from the unit.</p> <p>Policy and procedure was changed and unit laundry will be bagged and placed in barrel outside the unit. Laundry will be picked up twice daily. Laundry staff will place bagged laundry in a yellow bag for identification and move to new laundry barrel to take to laundry for processing.</p> <p>Hand Hygiene/PPE (Glove Use- Gloves are to be donned on entry to each room and doffed prior to leaving the room followed by hand hygiene. Per the hand hygiene policy gloves are to be donned prior to assisting resident and changed between dirty to clean tasks as well as upon every exit.</p> <p>Identification of other residents having the potential to be affected by the same deficient practice:</p> <p>All residents in the facility have the potential to be affected.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>All staff will be re-in-serviced by DON or designee and demonstrate competency on donning and doffing isolation PPE, hand washing procedures, and isolation procedures by 9/25/2020, or by next shift worked.</p>		

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F 880	<p>Continued From page 8</p> <p>When asked to describe the measures taken to prevent facility spread of COVID-19 after positive staff were identified in July 2020, IP said, "There was nothing to be done because we already required universal masking and face shields for all staff."</p> <p>IP stated the facility was "trying to conserve PPE (personal protective equipment) and required gowns be worn with only the highest risk residents. IP said he only required isolation gowns be used with transmission-based isolation precautions for COVID positive residents, roommates of COVID positive residents, those exposed to COVID, or those residents on the same HVAC (heating ventilation and cooling) system as COVID positive residents. IP explained that the HVAC system was segmented with one system covering about three resident rooms. IP said he determined who required transmission-based precautions based on the HVAC system. IP said the facility did not implement a PPE reuse strategy for gowns due to an increased risk for error with re-use". IP said the facility did not require staff wear gowns for transmission-based precautions for residents on the 500 hall for 14 day observation following admission or readmission. IP said the decision regarding not using gowns was based on "crisis capacity for PPE and CDC's ever changing guidance". However, during the initial interview, the administrator reported the facility had an adequate PPE supply. IP did not provide evidence the facility was at crisis capacity for PPE.</p> <p>IP provided an undated, 3-page facility document titled "Creekside Testing Plan" Section 5. New Admit Testing and screening read in part; *All new</p>	F 880	<p>All staff will be in-serviced by DON or designee, on the importance and requirement for resident hand hygiene and mask utilization by 9/25/2020, or by next shift worked.</p> <p>Education and Skills checks will be completed by DON or designee, on TS1 and MS1, NAC3, NAC4 and NAC2 regarding hand hygiene for staff and residents during meals by 9/25/2020, or by next shift worked.</p> <p>Facility will hold a resident council meeting on 9/25/2020 to discuss facility requirement of mask utilization and hand hygiene; residents will be encouraged to wear masks as tolerated when out of room. Individual education was provided to residents who were not in attendance to the resident council meeting.</p> <p>Beginning 9/25/2020, facility will ensure all outside contractors, including but not limited to Hospice, dental, NP's, Lab, x-ray, transport will be screened for proper donning and doffing procedures. Facility will be responsible to provide all necessary PPE during visits.</p> <p>Beginning 9/25/2020, facility will ensure all resident and family visitors are educated on proper donning and doffing procedures, hand hygiene, PPE utilization and social distancing. Each visitor will be required to meet with a designated facility member to ensure education, understanding and compliance.</p>		

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F 880	<p>Continued From page 9</p> <p>admits will be tested three times prior to removal of isolation/quarantine. Testing will be completed with 3 spaced out intermittent testing prior to removal of isolation protocol. Ongoing review of burn rate of PPE completed to determine PPE utilization and level of isolation precautions. *All new admits are placed on modified isolation precautions (standard plus droplet utilizing (gloves, face shield, or goggles) until 3 negative tests are returned. *After completion of 14 days of isolation with no s/sx [signs or symptoms] of COVID-19, resident is discontinued from droplet isolation.</p> <p>The facility policy titled; Infection Control and Prevention Policy; Emerging Infectious Disease (EID): Coronavirus 2019 (COVID-19), revised 6/12/20 identified four steps to take to minimize the spread 1. Isolate 2. Minimize contacts with all residents 3. Increase transmission-based precautions 4. Increase monitoring of residents and staff. On page 7 of 13, the policy read in part: Increase transmission-based precautions: As of June 11th, 2020 the facility PPE process is universal masking for all health care workers in the building. Residents are to be placed on droplet+ standard reaction (face shield, universal mask and gloves) until they have 2 negative COVID-19 nasal swabs. These tests are to be performed on day one and day four of admission. They are then moved to standard precautions and a third nasal swab will be performed on/around the 12th day of their stay. Test may vary depending on available supplies and resident wishes.</p> <p>The facility policy and practice was not consistent with CDC guidelines which required full PPE to include facemask, eye shield or goggles, gown,</p>	F 880	<p>Facility IP was removed from his position on 9/22/2020. New IP was hired to oversee facility Infection Control Program on 9/23/2020. New IP was educated to facility policies, surveillance procedures, CDC guidelines and tools on 9/24/2020.</p> <p>Surveillance logs will be completed timely, within 72hours of any suspected infection beginning 9/25/2020.</p> <p>Logs will clearly indicate when positive test results were received and corresponding action was taken, in addition the log will be clear on swab dates and on transfers or initiation of TBP (transmission based precautions).</p> <p>If a symptomatic resident is identified on a hall way, the rapid screening test will be utilized, if the rapid test is negative, a swab will be sent stat to the lab, while pending the results, that hall will be separated physically from the remainder of the facility by utilizing fire doors in the closed position. No entry from facility to the hall through these doors with the exception of clean linen/supply cart and food trays. When those items are delivered to fire doors, only cart and items will pass through doors, not staff. After hall has retrieved items from cart, the cart will be pushed out the outside facility exit at the end of hall and disinfected prior to being picked up to return to kitchen or place of origin. All staff will enter and exit through the outside facility door at the end of hall. Dedicated staff will be assigned to</p>		

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F 880	<p>Continued From page 10 and gloves when caring for residents during the 14-days following admission.</p> <p>Medical record review revealed R16 admitted to the facility (500 hall) on 7/14/20. A swab was obtained for COVID testing on 7/15/20. MDS note dated 7/19/20 at 11:20 noted post admission on 7/18/20 R16 was found to be COVID positive and placed on strict isolation precautions. The note read in part; on 7/19/20 she had and elevation of temperature of 99.9. She has CPAP (breathing machine for sleep apnea) at bedtime. Prior to going into isolation she was seen by PT [physical therapy] who worked with her on bed mobility, exercises, and transfers. She was seen by OT on 7/15/20 for functional ADL [activities of daily living] requiring moderate to maximum assist. The MAR indicated R16 was started on droplet precautions on 7/20/20 night shift. R16 received respiratory treatments, physical, occupational therapy, and nursing care for six days following admission without appropriate transmission-based precautions.</p> <p>A progress note written by the Director of Nursing Services on 7/18/20 indicated R16 was moved to the 400 COVID hall COVID unit due to the positive result of her COVID test that was performed on the 13th and facility was called with the positive results last night. A telehealth note written by the nurse practitioner on 7/21/20 indicated R16 tested positive for COVID-19 on 7/17/20. The "COVID Unit" surveillance log indicated R16 tested positive for COVID on 7/17/20, moved to the COVID unit on 7/17/20 and discharged to the hospital on 7/22/20.</p> <p>Review of the medical record review revealed R10 admitted to the facility on 7/17/20 from a</p>	F 880	<p>work the hall and will adhere to all PPE for the investigation period which is 14 days from last exposure on the hall. Dedicated staff will not work on other halls.</p> <p>Transmission based precautions will be implemented based on CDC standards and guidelines.</p> <p>Facility will use CDC transmission based precautions signage to identify residents with specific isolation precaution orders.</p> <p>The facility has reviewed the entire facility to ensure the proper signage is used for every resident 9/22/2020.</p> <p>Facility policy was updated to be consistent with CDC guidelines for Infection control practices for new admissions (ie: including transmission based precautions for 14 days, and use of gowns).</p> <p>All staff will be re-in-serviced by DON or designee, and demonstrate competency on new policy and procedures for Precautions for new admissions by 9/25/2020, or by next shift worked.</p> <p>The facility will audit all admissions for the past 14 days to ensure they are placed on appropriate transmission based precautions by 9/25/2020.</p> <p>Facility has amended their Policy and procedures to include assisted living facility admissions to the category of new admission and will follow the same</p>		

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F 880	<p>Continued From page 11</p> <p>separate assisted living facility located on campus. R10 admitted directly to the 100 hall room 111A. R10 was not placed on transmission-based precautions or isolation at the time of admission. Six days after admission, a nasal swab was collected on 7/23/20 for COVID testing. A progress note dated 8/12/20 noted R10 was "New COVID positive, asymptomatic [no symptoms]." Isolation, droplet precautions were ordered 8/13/20 at 6:00 PM. In an interview on 8/13/20 at 2:00 PM the DNS confirmed R10 was admitted directly to the 100 hall and was not placed on 14-day new admission observation or droplet precautions until R10 tested positive. The DNS said she did not consider R10 to be a new admission because she came from the Assisted Living Facility on campus.</p> <p>In a telephone interview the corporate clinical nurse (CNN) stated she was not aware IP changed the facility policy to not require gowns for droplet precautions. CCN concurred the changed facility policy was not consistent with CDC guidelines which required gowns.</p> <p>400 Hall observations: PPE and transmission-based precautions On 8/12/20 at 12:10 PM resident room 412 had a caddy hanging on the door that held one yellow gown, a box of gloves, and a container of disinfectant wipes. No signage was present to indicate to staff if R1 required precautions (aka; isolation) or what specific PPE was required to enter the room to care for R1. LN1 and NAC1 wore face masks and face shields. LN1 and NAC1 stepped inside room 412 and donned gowns that hung in the room and gloves then entered the room. A few minutes later, LN1 stood</p>	F 880	<p>transmission based precautions recommended by the CDC for new admissions.</p> <p>All staff will be re-in-serviced by DON or designee and demonstrate competency on new policy and procedures for new admissions (to include ALF Patients) by 9/25/2020, or by next shift worked.</p> <p>Social services will be provided one on one education by DON or designee on PPE usage, Observation of infection control signage, and appropriate hand hygiene by 9/25/2020, or by next shift worked.</p> <p>All staff will be re-in-serviced by DON or designee and demonstrate competency on Isolation precautions and CDC signage by 9/25/2020, or by next shift worked.</p> <p>Staff testing has been conducted per CMS guidelines and appropriate actions for contact tracing and infection control have been implemented per CDC guidelines.</p> <p>LN1 and NAC1 will receive additional One on one education by DON or designee on hand hygiene and donning and doffing to include appropriate disposal of gown if not re-usable by 9/25/2020, or by next shift worked.</p> <p>All staff will be re-in-serviced by DON or designee and demonstrate competency on donning and doffing isolation PPE, hand washing procedures, and isolation</p>		

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F 880	<p>Continued From page 12</p> <p>just inside the doorway and removed the gloves and then the gown. LN1 touched the front of the gown with both bare hands to feel for the waist tie. LN1 untied the gown and then pulled on the front of the gown pull it off her torso, then pulled the sleeves off by holding the cuffs. LN1 hung the gown on a hook on the wall. The gown hung with the outside of the gown facing outward and the gown touched another gown that hung nearby. The hooks and gown were not labeled. LN1 used ABHR [alcohol based hand rub] immediately after exiting the room.</p> <p>A few minutes later, NAC1 stood near the doorway and removed gloves and then gown. NAC touched the outside front of the gown with bare hands then contaminated the gown as she held the inside of the gown and hung the gown on top of a gown already hanging on a hook (stacked two gowns on one hook).</p> <p>In an interview upon exiting the room, LN1 said the gowns were to be "reused due to conservation mode." LN1 said each staff had their own gown for the room. When mentioned the gowns were not labeled, LN1 said "No, you just remember which is yours." When asked if they were hung correctly to prevent contamination when reused, LN1 replied "probably not, you should be able to put your arms right into the sleeves without touching the outside."</p> <p>On 8/12/20 at 12:25 PM IP was informed of the observation of gowns doffed improperly and stored improperly for reuse. IP said LN1 informed him about her response to questions about use of gowns for room 412. IP said LN1 gave the surveyor inaccurate information. IP said the disposable gowns were not intended for</p>	F 880	<p>procedures by 9/25/2020, or by next shift worked.</p> <p>All resident charts were reviewed, and Non-specific Isolation precaution orders have been clarified to provide specific isolation precautions on all residents as of 9/25/2020.</p> <p>All staff will be re-in serviced by DON or designee on donning and doffing isolation PPE, other on PPE usage, Observation of infection control signage, and appropriate hand hygiene, and isolation procedures by 9/25/2020, or by next shift worked.</p> <p>Nursing staff and visitation coordinators (screening staff) will be inserviced by DON or designee by 9/25/2020, or by next shift worked, regarding screening policies and procedures as well as CDC's latest visitation recommendations, and on notifying outside providers that they must comply with the CDC guidance including screening.</p> <p>All licensed nursing staff were trained by DON or designee by 9/25/2020, or by next shift worked, on proper storage, labeling and disposal of IV solution.</p> <p>Facility plan for monitoring performance to make sure solutions are sustained:</p> <p>Beginning the week of 9/28/2020, DON or designee will conduct random audits of proper donning and doffing, hand washing and isolation procedures (i.e. correct PPE utilization based on required precautions).</p>		

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F 880	<p>Continued From page 13</p> <p>reuse. The disposable gowns were one-time use to be discarded after use. IP said all staff were educated regarding use of disposable gowns. IP said LN1 was a unit manager and should know the expectations.</p> <p>IP was asked about R1's medical condition and any required transmission-based precautions. IP said R1 was moved from the 100 hall to the 400 hall on 8/11/20. IP said R1 had a negative COVID test but had persisting gastrointestinal symptoms so the facility was re-testing him. IP said he moved R1 to the 400 hall "until the test results come in." IP said the facility followed CDC guidelines so R1 was on droplet plus precautions. Regarding no signage to indicate the type of precautions and the required PPE to enter room 412; IP said, ideally the room should have signage, IP added "But the iso [referring to isolation] caddy was a visual clue that iso was needed."</p> <p>During an interview on 8/12/20 at 12:30 PM the DNS agreed there should be signage on room 412 regarding transmission-based precautions. DNS added "But staff use the door-hung supply caddy or the small cart next to the room as a visual clue." The DNS acknowledged there were different types of transmission-based precautions (aka, isolation) and the staff could not discern the required type of isolation or the specific required PPE from the caddy or cart.</p> <p>Observation on 8/12/20 at 12:35 PM revealed isolation caddies hung on two empty room doors on the 400 hall. Additionally a cart placed between resident rooms 409 and 411 was not labeled to indicate which room if any required isolation precautions.</p>	F 880	<p>Audits will be on 5 random employee□s each week X 4 weeks; then monthly x3 months to ensure compliance.</p> <p>Beginning the week of 9/28/2020, DON or designee will conduct hygiene and mask audits for both staff and residents, no less than daily X3 weeks for all shifts; then 3 times weekly x4 weeks for all shifts; then monthly x3 months for all shifts.</p> <p>Beginning the week of 9/28/2020, DON or designee will conduct audits of the visitation log to ensure all signed in family/resident visitors received education. Random audits will be completed 3x per week for the first 4 weeks; then 3x per month for 3 months.</p> <p>Audit/Review of IP certification and stated education will be conducted and signed off by outside consultant. Consultant will be able to show they have current IP certification and be able to demonstrate knowledge related to appropriate surveillance procedures, CDC guidelines and available tools.</p> <p>Beginning the week of 9/28/2020, the logs, surveillance procedures and implemented transmission based precautions and resident cohorting will be reviewed by outside consultant monthly x3 months.</p> <p>Beginning the week of 9/28/2020 DON or Designee will audit all admissions to ensure that they are placed on appropriate transmission based</p>		

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	<p>Continued From page 14</p> <p>IP placed signage on room 412 door indicating droplet plus contact precautions required and, dispose of gowns after use. The signage read: Droplet and Contact Precautions. Bed ____.</p> <p>Families and visitors STOP. Please report to staff before entering. Clean hands before entering and when leaving room. Graphic images of ABHR (alcohol based hand rub) and handwashing with text; clean hands with A. hand foam/gel or B. soap and water. Staff: KEEP SIGN POSTED UNTIL ROOM CLEANED.</p> <p>HOUSEKEEPER will remove sign after "Discharge cleaning". POINT of CARE Risk Assessment. Gown and Gloves. Procedure mask with eye protection-when within 2 metres of patient. Keep 2 metres between patients. The sign indicated it was produced by PICnet, (provincial network of British Columbia), a program of the Provincial Health Services Authority.</p> <p>When asked why the facility did not use resources and signage available through CDC, in a written response, IP wrote that he felt the PICnet signs "better encompassed our infection control protocols" IP's response indicated the PICnet signage matched the CDC recommended guidelines. IP wrote: "My rationale was that it is more complete and easy to edit in the case of adding a N95 (for example) to the precautions as recommendations have changed over the course of the COVID-19 season." IP further wrote; "Droplet plus contact precautions signs are used for the COVID unit (because it includes the N-95 mask) while Contact-Plus is used upon admit residents, and the point of care assessment can be over ruled due to the fact that surgical mask or higher and face shield is required center wide."</p>		<p>precautions. Audits weekly x 4 weeks, then monthly x 3 months. Issues identified will reported to nursing management.</p> <p>Beginning the week of 9/28/2020 DON or designee will conduct random audits of proper donning and doffing, hand washing and isolation procedures (i.e. correct PPE utilization based on required precautions). Audits will be on 5 random employee's each week X 4 weeks; then monthly x3 months to ensure compliance.</p> <p>Beginning the week of 9/28/2020 DON or Designee will complete an audit of infection control signage to ensure appropriate observance by staff (i.e. correct PPE utilization based on required precautions). Audits will be on 5 employees weekly x 4 weeks, then monthly x 3 months. Issues identified will reported to nursing management.</p> <p>Beginning the week of 9/28/2020 DON or Designee to complete an audit on isolation precaution orders weekly x 4 weeks, then monthly x 3 months. Issues regarding isolation orders will be reported to nursing management.</p> <p>Beginning the week of 9/28/2020 DON or designee to complete audits of the screening log's inclusion of outside providers will be conducted weekly x 4 weeks, then monthly x 3 months. Issues regarding visits without Screening will reported to nursing management.</p>		

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F 880	<p>Continued From page 15</p> <p>The PICnet Contact Plus Precautions sign directed; Contact Plus Precautions-Used for Clostridium Difficile Infection (CDI) Only. Clostridium Difficile is a bacterium that causes severe diarrhea". Contact Plus sign showed a picture of a person wearing gown and gloves but no facemask or eye shield. And directed Staff: Required gown and gloves. The sign read; Point-of-Care-Assessment. When there is a risk of splash or spray, wear face and eye protection.</p> <p>The facility policy titled "Infection Control and Prevention Policy- Emerging Infectious Disease (EID): Coronavirus Disease 2019, revised 6/12/20 read in part; Procedure: 1. Minimize Chance for Exposures interventions included *Identify, stock, and staff separate designated areas of the building to room:-Diagnosed COVID-19 positive resident(s) or suspected (symptomatic residents -Suspected COVID-19 positive resident (post exposure) pending test results and -New admissions to the building for 14 days (observation) may include dialysis residents (potential community exposure). *Ensure rapid safe triage and isolation of patients with symptoms of suspected COVID-19 or other respiratory infection.</p> <p>2. Adhere to Standard and Transmission-Based Precautions. Read in part; Attention should be paid to training and proper donning (putting on), doffing (taking off), and disposal of any PPE. Personal Protective Equipment; HCP (health Care professional) must receive training on and demonstrate an understanding of: when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination, how to properly dispose of or disinfect and maintain PPE, and the limitations of</p>	F 880	<p>Beginning the week of 9/28/2020 DON or Designee will complete an audit of infection control during mealtime services to include staff and resident hand hygiene will be conducted weekly x 4 weeks, then monthly x 3 months. Issues identified will reported to nursing management.</p> <p>Beginning the week of 9/28/2020 the DON or designee will audit weekly for proper IV solution labeling, usage and disposal. be conducted weekly x 4 weeks, then monthly x 3 months.</p> <p>All audits will be reviewed by the QAPI committee who will determine continuation of audits based on findings presented and reviewed monthly during QAPI meeting.</p>		

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F 880	<p>Continued From page 16 PPE.</p> <p>The facility policy and procedure regarding transmission-based precautions, the PICnet signage, and directions for precautions were not consistent with the CDC guidelines which required an N95 mask, eye protection, gown, and gloves for care of residents suspected to have COVID-19, known COVID positive, and during the 14 day observation period following admission or readmission.</p> <p>From CDC website at www.cdc.gov. Preparing for COVID-19 in Nursing Homes Updated June 25, 2020</p> <p>Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community.</p> <p>Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.</p> <p>Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g. outside of resident's room, wing, or facility-wide).</p> <p>Review of Centers for Disease Control and Prevention (CDC) cases and deaths by county,</p>	F 880			

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F 880	<p>Continued From page 17</p> <p>https://www.cdc.gov/coronavirus/2019-ncov/case-s-updates/county-map.html showed Ada County, where the facility is located, had 2,104 cases per 100,000 which indicated high community COVID-19 activity.</p> <p>Compassionate visit Review of R5's medical record revealed a medical provider note dated 7/28/20 noted R5 "has been isolating in her room currently with her spouse (R6) as he has been having a fever and is 'not feeling well'.</p> <p>Review of R6's medical record revealed a physician order dated 7/18/20 that read "Isolation precautions per facility protocol. The order did not specify what type of precautions and did not specify the reason for precautions. No directions were specified for the order and the order was not entered onto the medication or treatment record. The record did not reflect whether the precautions were implemented on 7/18/20 and the daily charting did not document isolation precautions. Progress notes written 7/27/20 noted R6 had elevated temperature at 101.1 and abnormal lung sounds. A progress note dated 7/30/20 noted R6 continued on antibiotics for pneumonia and was on "gown isolation."</p> <p>Observation conducted on 8/12/20 from 1:18 PM to 1:25 PM revealed no signage to indicate precautions for R5 and R6's room 106. NAC2 said room 106 was not on isolation. NAC2 was asked to identify persons in room 106. NAC2 identified a family member, a hospice nurse and social service staff. NAC2 said it was a compassionate visit for hospice. The family member at R5's bedside did not wear a facemask. The hospice nurse wore a facemask</p>	F 880			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 18</p> <p>and eye protection but no gloves and no gown and leaned on the overbed table. Several staff came and went from the room at various times wearing face mask and eye shield but no gown or gloves. Hospice nurse, family, and facility staff engaged in comforting behaviors such as rubbing R6's back and patting shoulders, no hand hygiene was performed following such comfort measures. Social distancing was not maintained. Four hours later, positive COVID test results were reported for R5 and R6 at 5:40 PM on 8/12/20 and both were transferred to the COVID unit.</p> <p>Potentially contaminated intravenous fluid available for use On 8/12/20 at 11:45 AM a bag of 0.9% NACL (Normal saline) hung on a pole in the 400 corridor outside room 412. The bag was spiked (bag punctured to attach tubing). The IV solution label had no date to show when it was opened (spiked) and no resident name or room number. LN1 exited room 412 and was asked about the IV solution. LN1 said she did not know anything about it, no resident on the hall needed IV fluids.</p> <p>On 8/12/20 at 11:47 AM, when shown the IV solution hanging on the pole, IP confirmed no current resident required IV fluid and said he would investigate. IP returned at 12:30 PM and reported he thought staff got the IV fluid ready to give to R2, but R2 went out to the hospital so they probably did not have time to start the IV. IP said R2 went to the hospital "around the 4th or 5th". IP said the IV solution should have been labeled with the date and time it was spiked and the resident's name. IP said the IV solution was not safe, because it could be contaminated with bacteria. IP said IV fluid should be used within 24 hours after it is opened or spiked, but added he</p>	F 880			

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F 880	<p>Continued From page 19</p> <p>"doubted anyone would use it". IP discarded the IV solution.</p> <p>Outside Professional Provider On 8/12/20 at 12:06 PM observed personnel P1 in room 408 as she washed her hands. P1 wore a face mask, face shield, and a gown. When asked about PPE requirements in the facility, P1 responded that she did not know because she was not facility staff. P1 explained she came into the facility with the dentist to provide dental exam and dental treatment to residents, and added, "We wear this gown when we are working on residents."</p> <p>IP was called to the 400 hall. When IP was asked if the dentist and his staff were screened and instructed in the use of PPE, facility restrictions/process regarding movement of residents in the facility, where treatment would be provided, and which residents would be treated; IP said he did not know the dentist was in the building, IP said only essential services were to be allowed in the building and he should have been consulted before the dentist came into the facility.</p> <p>IP concurred dental treatment would be considered aerosol generating procedure (AGP) with increased risk for transmission of COVID-19. When asked the facility expectation for dental examination and treatment in the facility, IP said the dental staff would need full PPE including N95 facemask, face shield, gowns, and gloves due to the increased risk with AGP. IP said he obtained more information and reported the dentist came to the facility because two residents had pain. IP said both residents had negative COVID tests. IP said the dentist brought his own reusable</p>	F 880			

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F 880	<p>Continued From page 20</p> <p>washable gown which the dentist reported he wore. IP said he placed disposable gowns in room 408 and instructed the dentist and his staff to use disposable gowns, one gown per resident.</p> <p>IP said the dentist stated last Thursday [6 days prior] he was in a skilled nursing facility that had COVID-19. When asked about screening of the dentist for facility entry; IP said the screening should have identified that the dentist was in a COVID positive building 6 days earlier and either he [IP] or the DNS should have been informed to review the screening information and to provide direction regarding allowing access to the residents. IP reported social services set up the dental visit and the DNS was also unaware the dentist was in the building.</p> <p>Resident hand hygiene Observed distribution of lunch trays on 8/12/20 from 12:46 PM to 12:58 PM on the 300 hall. Transportation staff TS1 and maintenance staff MS1 assisted. TS1 delivered a meal tray to room 313 and set up the tray on the overbed table. TS1 did not perform hand hygiene when exiting the room. TS1 got a tray from the tray cart which he delivered to room 311 with no hand hygiene when entering or exiting the room. Observed trays delivered by various staff to rooms, 306, 308, 311, 313, and others with no pre-meal hand hygiene provided or offered to the residents. Similarly on the 100 hall NAC2 delivered and set up trays in rooms 106, 108, 114, and others without providing or offering the residents pre-meal hand hygiene.</p> <p>Observation of the evening meal on 8/12/20 from 5:00 PM to 5:25 PM revealed NAC4 delivered trays on the 200 hall to residents in rooms 205,</p>	F 880			

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F 880	<p>Continued From page 21</p> <p>201, 203, 209, and 212. Residents were not provided or offered hand hygiene prior to the meal. The meal included sloppy joes, French fries, and vegetables. Residents ate the sloppy joes and French fries with their fingers. Evening meal observations conducted on the 300 hall revealed similar findings of no hand hygiene offered or provided by NAC3, unit manager, or Staff 1 to residents in rooms 308, 311, 312, and 313.</p> <p>CMS State Operations Manual: If residents need assistance with hand hygiene; staff should assist with washing hands after toileting, before meals, and use of ABHR or soap and water at other times when indicated.</p> <p>Observations 8/13/20 On 8/13/20 at 8:40 AM R3 stood at the door in room 408 and requested assistance. Social service staff SS sat in an office nearby and was informed of the request. SS did not perform hand hygiene before she donned a facemask and face shield that sat on her desk. SS went to room 408 and donned gloves and then a gown and entered the room. SS said last night R3 moved to 408 from another unit. SS said R3 did not test positive for COVID-19 but she was exposed so she had to move to a new room. Signage on the door indicated droplet plus contact precautions. IP confirmed R3 was a relative and had close personal contact with two residents who tested positive for COVID-19.</p> <p>R1 was no longer in room 412. Review of the census log for 8/13/20 revealed the facility made eight room changes overnight; R1 moved from 412B to the COVID unit, R4, R5, R6, and R10 moved from the 100 hall to the COVID unit and</p>	F 880			

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F 880	<p>Continued From page 22</p> <p>R7, R8, and R9 moved out of the COVID unit to the 400 hall. The census log did not reflect R3's move from 110A to 408.</p> <p>Observation of the 100 hall at 10:00 AM revealed five resident rooms (109, 110, 112, 113, and 114) had signage indicating droplet precautions required. No rooms on the 100 hall required droplet precautions on 8/12/20. NAC5 said she was not told of concerns at 6:00 AM report, but then at 9:00 AM she noticed the isolation signs were up. NAC5 said she thought one resident was positive. NAC5 said she was informed it "was precautionary, a roommate came back so be aware of that, watch for symptoms, wash hands, gown up and put on gloves and face shields and have resident wear a mask."</p> <p>In an interview on 8/13/20 at 10:30 AM IP said two employees who worked on the 100 hall tested COVID-19 positive around July 27, 2020 so the facility conducted COVID testing of all residents on the 100 hall. IP said the facility received a call last evening at 5:40 PM with the first results confirming COVID positive test results for 5 of 25 residents on the 100 hall (R1, R4, R5, R6, and R10). Test results for 20 residents were still pending.</p> <p>When asked to describe the measures the facility implemented to contain the outbreak on the 100 hall, IP said R1 was moved to the 400 hall on 8/11/20 because he spiked a temperature. IP said he "was going under the assumption that R1 was negative when he moved him, but he [R1] turned up positive." IP said R10 was moved to the 400 hall on 8/12/20 because she was exposed through close contact (regular visits) with two positive residents."</p>	F 880			

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F 880	<p>Continued From page 23</p> <p>When asked why residents in only five 100 hall rooms were identified for droplet precautions and shouldn't all residents on the 100 hall be isolated. IP said he based his decision on the HVAC system. IP said he did not consider it necessary to "lock down" or quarantine the entire 100 hall. Discussed CDC guidelines that all recommended COVID 19 PPE should be used during care of all residents on the affected unit or facility. IP said "it was not necessary and it was not in the facility plan to isolate an entire unit." IP said "closing the unit would have been primo, but psychosocial needs trumped that."</p> <p>The nursing schedule showed staff worked on more than one unit or hall. On the 8/11/20 actual working schedule for all three shifts the licensed nurse and nursing assistants had 100 hall and 400 hall residents assigned. The 200 hall licensed nurse and nursing assistants had 200 and 400 hall residents assigned. IP confirmed staff floated and or were shared between two halls. IP said the facility was "a little short on CNAs" due to family needs. IP said the facility as short but not critical.</p> <p>IP said the facility "mapped out who we could afford and reduced the flow onto that unit". IP said the facility did not have enough PPE for the entire 100 hall. IP estimated if he required full PPE for all residents on the 100 hall, he would have enough PPE for only 6 days. IP added, the facility could not close the doors to the 100 hall because "he knew of one resident would freak out" and closing the doors to the unit could cause psychological harm and could also result in cold meals. IP said he "isolated roommates of COVID positive residents and determined residents at</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2020
NAME OF PROVIDER OR SUPPLIER CREEKSIDE TRANSITIONAL CARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
(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 880	<p>Continued From page 24</p> <p>risk based on the HVAC circuits/zones." IP added; "We [facility] do not need to do more." IP summarized his approach: "universal testing, map out the highest risk, and move positives."</p> <p>In a telephonic meeting on 8/17/20 CCN and the administrator acknowledged the survey findings and agreed that immediate action was needed to contain COVID to the 100 hall. CCN reported an additional 10 residents on the 100 hall were confirmed positive for COVID-19. Now 15 of 25 (60%) of residents who resided on the 100 hall were positive.</p> <p>CCN said the facility began implementation of actions to include closing off the 100 hall with only assigned staff dedicated and use of full PPE. CCN said she was not aware the facility changed the policy to not require gowns with droplet precautions for new admissions and policy and procedure would be reviewed to ensure compliance with CDC recommendations and guidelines. CCN said the facility would implement a comprehensive infection surveillance system and started a program of staff re-education regarding proper use of PPE.</p> <p>At the conclusion of the onsite survey on 8/13/20 at 4:00 PM the facility administrator and the DNS were informed the immediate jeopardy was ongoing.</p>	F 880			