STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN FALLS TRANSITIONAL CARE OF CASCADIA	674 EASTLAND DRIVE TWIN FALLS, ID 83301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** 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: 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: 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. 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. - 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. - 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. 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. - 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. - 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. 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. 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. 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. 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 on to LPN #1's bare hand rather than in the medication cup. LPN #1 then put the pills into the medication cup. 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. LPN #1 entered Resident #3's room and administered the medications. 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 on to 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. 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. 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. 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. The facility's Standard Precautions policy, dated 11/15/19, directed staff to wear gloves when potential exposure to bodily fluids was anticipated and to change gloves and perform hand hygiene after contact with residents' environment and between tasks. These policies were not followed. 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. 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. 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 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. 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

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

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) solution. She took the rag with the toilet bowl cleaner and caddy and could be heard cleaning in Resident #2's bathroom. 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. 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 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. 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. On 7/1/20 at 11:54 AM, Housekeeper #1 said she did not perform hand hygiene after removing her 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. 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. 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. 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. 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. 3. The Clorox Bleach Germicidal Cleaner directions for cleaning and disinfecting nonporous surfaces was to spray 6 to 8 inches from the surface until the surface is thoroughly wet and allow this product to remain wet for one minute. This direction was not followed. 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. 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. 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.