STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135138	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TETON POST ACUTE CARE & REHABILITATION	**3111 CHANNING WAY IDAHO FALLS, ID 83404**

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** - Few	**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 staff performed hand hygiene 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: The facility's Handwashing/Hand Hygiene policy, dated 4/2018, stated to use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water before and after direct contact with residents. On 8/25/20 at 11:34 AM, RN #1 was observed adjusting Resident #1's right leg and leg-lift on his wheelchair. RN #1 was standing at the medication cart preparing to distribute medications when Resident #1 approached RN #1 in his wheelchair. RN #1 commented that his right foot, protected by a foam boot, was pressed against the footrest and should not be. RN #1 proceeded to adjust the leg lift to a higher position and adjust his leg on the leg rest touching Resident #1 and his wheelchair. RN#1 then provided Resident #1 with his medications and used the computer mouse to document administration of Resident #1's medications. RN #1 did not perform hand hygiene after touching Resident #1 and his wheelchair and between providing his medications and touching the computer mouse and medication cart. On 8/25/20 at 11:40 AM, the RN said she did assist Resident #1 in his wheelchair and forgot to sanitize her hands after touching his leg and wheelchair and before touching the medication cart, computer mouse, and administering Resident #1 his medications. On 8/25/20 at 12:30 PM, the DON said RN #1 should have performed hand hygiene after touching Resident #1 and his wheelchair.

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.