STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an Advance Directive. This was true for 1 of 20 Residents (Resident #7) whose records were reviewed for Advance Directives. This deficient practice created the potential for harm or adverse outcomes if the resident's wishes were not followed or documented regarding their advance care planning. Findings include: Resident #7 was admitted to the facility on [DATE], with diagnoses including Spotted Fever due to Rickettsia rickettssi (disease caused by the bite of a tick or mite) and diabetes. On 6/10/25 at 10:02 AM, during review of Resident #7's medical record a POST and a Letter of Guardianship was found. No documentation of Advance Directive and no documentation that the facility had offered to assist Resident #7 or resident guardian with formulating an Advance Directive. On 6/10/25 at 11:47 AM, CRN stated Resident #7 has a guardian so Advance Directives were not discussed and no Advance Directive documentation exists.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected resident's status. This was true for 2 of 20 residents (#32 and #38) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: 1. Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including PTSD, major depressive disorder, and anxiety. Resident #32's PASRR level II dated 12/13/24, documented she had a diagnosis of PTSD (serious mental illness), ADD, and situational anxiety/depression. Resident #32's admission MDS assessment, dated 12/23/24, documented under question A1500, she was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. Resident #32's admission MDS assessment dated [DATE], and her quarterly MDS assessment dated [DATE], did not document under section I6100 her diagnosis of PTSD. 2. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder, fractured right femur, and complication of internal left hip prosthesis. Resident #38's admission MDS assessment dated [DATE], documented under question A1500, he was not considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. On 6/11/25 at 2:30 PM, the CRN with the CCO present, stated Resident #32's MDS, section A1500, should have been marked yes and I6100 should have indicated she had a diagnosis of PTSD. On 6/11/25 at 2:35 PM, the CRN with the CCO present, stated Resident #38's MDS, section A1500, should have been marked yes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness, intellectual disability, or a related condition. This was true for 1 of 8 residents (Resident #58) reviewed for PASARR Level II evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: The facility's Pre-admission Screening and Resident Review (PASARR) policy dated 11/19/24, documented if a positive Level 1 screen, an in-depth evaluation (PASARR Level II screen) of the individual by the state-designated authority is conducted prior to admission to the facility. The state-designated authority determines whether the individual has a mental disorder (MD) or an intellectual disability (ID) or related condition. The state-designated authority determines the appropriate setting for the individual and recommends what, if any, specialized services and/or rehabilitative services the individual needs. The facility's Interdisciplinary Team uses the PASARR when conducting their assessments of the resident, developing the care plan, and when transitions of care occur to promote a comprehensive assessment and development of a plan of care for residents with MD or ID. Resident #58 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including acute and chronic respiratory failure with hypoxia (a situation where the lungs fail to adequately transfer oxygen into the bloodstream, leading to low tissue oxygen levels) and post-traumatic stress disorder (PTSD - a mental health condition that can develop after experiencing or witnessing a traumatic event). Resident #58's medical record documented he was diagnosed with post-traumatic stress disorder with an onset date of 1/30/25. On 6/9/25, Resident #58's medical record documented the following related to PASRR and MDS reviews: - PASRR I dated 1/30/25, documented depressive disorder and Bipolar disorders. - PASRR II dated 1/30/25, documented Resident #58 has the diagnoses of Anxiety, Depression, Bipolar Disorder for which medication is prescribed. Documents did not state concerns related to mental health. No further evaluation for specialized service needed. - MDS dated [DATE], under I6100 PTSD was not marked YES. - PASRR I dated 2/27/25, documented depressive and anxiety disorder, Bipolar disorders, and PTSD. - PASRR II dated 3/4/25, documented Resident #58 has depression, anxiety, bipolar, and PTSD. He is prescribed Lamictal and Latuda to treat mental illness. Sending PASRR forward to MH for further review. - PASRR I dated 4/8/25, documented depressive disorder and Bipolar disorders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- PASRR II dated 4/8/25, documented Resident #58 has the diagnoses of bipolar disorder and depression for which medication are prescribed. No further evaluation needed. - PASRR II dated 4/22/25, documented Resident #58 has the diagnoses of Depression and Anxiety for which medication is prescribed. Documents did not state concerns related to mental health. No further evaluation for specialized service needed. - PASRR I dated 5/1/25, documented depressive disorder, Bipolar disorders, and PTSD. - PASRR II dated 5/2/25, documented Resident #58 readmitted to hospital with plan to return to skilled nursing facility. Documentation shows suicidal ideation; mental health diagnoses bipolar, PTSD, depression, and anxiety; medications prescribed Hydroxyzine, Lamictal, and Latuda. - MDS 5/9/25, I6100 PTSD was marked yes. - PASRR I dated 5/29/25, documented depressive disorder and Bipolar disorders. - PASRR II dated 5/29/25, documented Resident #58 has depression, anxiety, and bipolar; medications to treat mental health Gabepentin, Hydroxyzine, Lamotrigine, and Lurasidone. On 6/10/25 at 9:10 AM, the Social Services Manager stated she had missed the errors on the past PASSR's and had just requested a PASRR I and PASRR II corrections as listed below. - PASRR I dated 6/9/25, documented Resident #58 has depression, anxiety, bipolar, and PTSD. - PASRR II dated 6/10/25, documented facility requested new PASRR review due to incorrect form 87. Resident #58 has diagnoses of depression, anxiety, bipolar, PTSD, and insomnia due to other mental disorder. On 6/10/25 at 10:05 AM, the CNO and CRN stated the facility staff should have caught these PASRR I and II errors and requested corrections but had not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to resubmit the PASRR level II for those residents with a 30 day exemption when their stay exceeded 30 days. This was true for 3 of 20 residents (#12, #38, and #63) reviewed for PASRR level II evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include. 1. Resident #12 was admitted to the facility on [DATE], with multiple diagnoses including depression, anxiety, and congestive heart failure. Resident #12's PASRR level II dated 8/5/24, documented the following: - Meets the criteria for hospital exemption - Has a known or suspected major mental illness - Physician has certified he will need less than 30 calendar days for services. - If the participant stays past 30 days from admission, the facility was to submit the most current MDS, Medical Doctors orders, social notes, and psych. information to BLTC. 2. Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including major depressive disorder, fractured right femur, and complication of internal left hip prosthesis. Resident #38's PASRR level II dated 4/3/25, documented the following: - Meets the criteria for hospital exemption - Has a known or suspected major mental illness - Physician has certified he will need less than 30 calendar days for services. - If the participant stays past 30 days from admission, the facility was to submit the most current MDS, Medical Doctors orders, social notes, and psych. information to BLTC. On 6/10/25 at 12:54 PM, the CRN stated the facility did not submit the most current MDS, Medical Doctors orders, social notes, or psych. information to BLTC for residents #12 and #38 and should have. 3. Resident #63 was admitted to the facility on [DATE], with multiple diagnoses including Autonomic Nervous System disorder (conditions that disrupt the body's ability to regulate involuntary functions like heart rate, blood pressure, digestion, and temperature), Parkinson's Disease (a progressive neurodegenerative disorder that affects the brain, specifically the nerve cells that produce dopamine), and borderline personality disorder (characterized by severe mood swings, impulsive behavior, and difficulty forming stable personal relationships). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25, Resident #63 medical record documented the PASRR level II dated 3/11/25, would need to be resubmitted with current MDS, Medical Doctor orders, social notes and psych. information to BLTC for update if her stay at the facility exceeded 30 days. On 6/10/25 at 9:10 AM, the Social Services Manager stated she had recently found this issue and had resubmitted required documents to BLTC for review. On 6/10/25 at 10:05 AM, the CNO and CRN stated the facility staff should have caught this PASRR level II error back in April 2025 and requested an updated PASRR level II but had not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, it was determined the facility failed to provide respiratory services as ordered by the physician and the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment when staff used opened oxygen supplies after it had fallen on the floor. This was true for 2 of 15 residents (Resident #63 and #41) whose records were reviewed for respiratory services. This failure created the potential for residents to experience increased fatigue, low oxygen levels and infection. Findings include: 1. Resident #63 was admitted to the facility on [DATE], with multiple diagnoses including Autonomic Nervous System disorder (conditions that disrupt the body's ability to regulate involuntary functions like heart rate, blood pressure, digestion, and temperature), Parkinson's Disease (a progressive neurodegenerative disorder that affects the brain, specifically the nerve cells that produce dopamine), and borderline personality disorder (characterized by severe mood swings, impulsive behavior, and difficulty forming stable personal relationships). Resident #63's care plan dated 3/31/25, documented oxygen therapy as ordered. Change disposable oxygen tubing, nebulizer supplies, connecting tubing, corrugated tubing, etc weekly. Resident #63's TAR for June 2025, RN #5 documented oxygen tubing and bubbler were changed on 6/5/25. On 6/9/25 at 9:37 AM, observed Resident #63's oxygen concentrator tubing and empty bubbler were dated 5/30/25 as the last changed date. On 6/9/25 at 1:30 PM, with the CEO present, observed Resident #63's empty bubbler and tubing that were dated 5/30/25. On 6/10/25 at 10:46 AM, the CRN stated the night nurse told her she had assigned the task of changing the O2 tubing and humidifiers to the CNAs and then she spot checked a few rooms to make sure it was done but did not check Resident #63's room and should have. 2. Resident #41 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including congestive heart failure (a chronic condition where the heart is unable to pump enough blood to meet the body's needs, leading to fluid buildup in the lungs and other tissues) and chronic respiratory failure with hypoxia (a condition where the lungs are unable to effectively exchange oxygen and carbon dioxide in the blood over a prolonged period, resulting in chronically low blood oxygen levels). On 6/10/25 at 2:27 PM, observed CNA #1 drop Resident #41's oxygen cannula tubing end on the ground when filling his liquid portable unit. On 6/10/25 at 2:31 PM, observed CNA #1 pick-up Resident #41's oxygen cannula tubing from the ground and reconnect it to his liquid portable unit while he was in the resident council meeting. On 6/10/25 at 2:35 PM, CNA #1 stated he should not have dropped Resident #41's oxygen cannula tubing end on the ground and should not have reused that tubing on his oxygen unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 2:39 PM, the CRN stated CNA #1 should have replaced Resident #41's dropped cannula tubing before reconnecting it to the portable oxygen unit and did not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 2 of 3 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: On 6/8/25 at 3:42 PM, during 400 Hall medication cart audit, observed the narcotic accountability record, dated 6/4/25 to 6/8/25, with 2 licensed nurse signatures not documented. On 6/8/25 at 3:45 PM, LPN #2 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 6/11/25 at 7:56 AM, during 100 Hall medication cart audit, observed the narcotic accountability record, dated 6/5/25 to 6/11/25, with 1 licensed nurse signature not documented. On 6/11/25 at 8:05 AM, LPN #3 stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart. On 6/11/25 at 2:35 PM, CNO stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and staff interview, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 medications (5.71%) which affected 1 of 6 residents (Resident #38) whose medication administrations were observed. This failed practice placed residents at risk of not receiving their prescribed medication or dosage of their medication. Findings include: The following was observed during the medication pass: a. Resident #38's physician order documented Calcium 600mg/Vitamin D 10 mcg oral tablet daily. On 6/11/25 at 8:17 AM, LPN #3 stated Resident #38 had been receiving Calcium 600mg/Vitamin D 10 mcg in chewable form and the facility did not have chewable tablets so she could not administer the medication. On 6/11/25 at 8:50 AM, CNO stated the facility did not have Calcium chewable tablets available to administer to Resident #38. b. Resident #38's physician order documented Lidocaine External patch 4% (Lidocaine) apply to left leg base topically one time a day for pain, on for 12 hours in AM and off at PM. On 6/11/25 at 8:24 AM, LPN #3 removed a previously applied Lidocaine patch from Resident #38's left leg base then applied a Lidocaine External patch 4% (Lidocaine) to his left leg base. On 6/11/25 at 8:37 AM, LPN #3 stated the lidocaine patch should be removed after 12 hours and had not been. On 6/11/25 at 8:38 AM, LPN #3 stated the Lidocaine patch is hard to write on so she did not date, time, initial the patch. On 6/11/25 at 11:20 AM, CNO stated the Lidocaine patch should have been removed in the PM and had not been, and the Lidocaine patch should have been dated, timed, initialed by the LPN and had not been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews it was determined the facility failed to ensure medications were properly stored and not expired, and biologicals were labeled when opened. This was true for 1 of 1 medication storage room audited. This failure created the potential for residents to receive expired medications with decreased efficacy and use of expired biologicals. Findings include: 1. On 6/11/25 at 8:52 AM, observed the following in the medication storage room refrigerator: - one bottle of mouthwash opened with an expiration date of 4/17/25 - two bottles of omeprazole suspension with an expiration date of 4/17/25 On 6/11/25 at 8:53 AM, CNO stated the mouthwash and omeperazole suspension was expired and should have been removed from the refrigerator and had not been. 2. The following was observed for biologicals. On 6/11/25 at 8:54 AM, one set of glucose test solutions were not dated when opened. On 6/11/25 at 8:55 AM, CNO stated glucose test solution was not dated when opened and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, Idaho Food Code review, policy review, and staff interview, it was determined the facility failed to ensure the food was stored in a safe and sanitary manner. These deficiencies had the potential to affect all residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include: The Idaho Food Code, revised February 2021, stated, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking . refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. The facility's Food and Supply Storage policy dated 11/28/17, documented for food products that are opened and not completely used or prepared at facility and stored, the product should be labeled as to its contents and use-by dates. On 6/8/25 at 9:56 AM, observed in the dry food storage room, opened container of dry scalloped potatoes with a use by date of 6/7/25. On 6/8/25 at 10:00 AM, observed in the walk-in refrigerator, an undated container of tea and a tray of individually poured cups of juice that were not dated and the tray they were on was not dated. On 6/8/25 at 10:04 AM, observed in the walk-in freezer, a bag containing pizzas that had been opened but had not been dated. On 6/8/25 at 10:07 AM, the Culinary Manager stated these food items should have been properly dated and were not.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure accurate data was entered into a resident's medical record. This was true for 1 of 20 residents (Resident #51) whose medical records were reviewed. This deficient practice placed residents at risk when inaccurate medical data is entered into their medical records. Findings include: Resident #51 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including chronic congestive heart failure (a long-term condition where the heart's pumping ability is weakened, leading to fluid buildup in the lungs and other parts of the body) and chronic obstructive pulmonary disease (a group of lung diseases that cause long-term breathing problems). Resident #51's physicians' order dated 6/2/25, documented BIPAP with home settings with oxygen at 2 liters with humidification. On 6/10/25, observed in Resident #51's medical record the following SpO2 documentation: - 6/3/25 14:13 90.0% Oxygen via Nasal Cannula LPN #1 - 6/2/25 14:01 96.0% Oxygen via Nasal Cannula LPN #1 - 5/22/25 21:58 94.0% Oxygen via Nasal Cannula RN #1 - 5/21/25 7:06 93.0% (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxygen via Nasal Cannula LPN #2 - 5/16/25 10:28 94.0% Oxygen via Nasal Cannula LPN #3 - 5/6/25 9:36 94.0% Oxygen via Nasal Cannula RN #2 - 4/21/25 9:49 93.0% Oxygen via Nasal Cannula RN #2 - 4/20/25 9:02 93.0% Oxygen via Nasal Cannula RN #3 - 4/16/25 9:13 94.0% Oxygen via Nasal Cannula LPN #3 - 4/11/25 8:04 92.0% (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxygen via Nasal Cannula RN #2 - 4/6/25 19:41 92.0% Oxygen via Nasal Cannula RN #4 - 4/5/25 23:40 91.0% Oxygen via Nasal Cannula RN #5 - 4/2/25 21:25 94.0% Oxygen via Nasal Cannula RN #1 - 3/30/25 9:33 96.0% Oxygen via Nasal Cannula LPN #3 - 3/29/25 12:36 94.0% Oxygen via Nasal Cannula RN #6 On 6/10/25 at 9:53 AM, the CNO stated Resident #51's oxygen order was for oxygen used with his BIPAP and not with a nasal cannula and there was no cannula in the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 10:33 AM, the CRN stated the SpO2 nasal cannula issues were documentation errors and should have been caught and corrected.