STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KARCHER POST-ACUTE & REHABILITATION CENTER	**1127 CALDWELL BOULEVARD NAMPA, ID 83651**

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 -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, nationally recognized standards of practice, policy review, review of the facility list of COVID-19 positive testing results, and review of employee screening logs, work schedules, and timesheets, the facility failed to ensure infection control prevention practices were implemented and maintained to prevent and contain COVID-19. These failures placed all residents and staff at risk for exposure to COVID-19 with the likelihood of serious harm impairment, or death. Findings include: 1. The facility's policy for Coronavirus COVID-19, revised 7/28/20, documented staff and visitors were directed to an entry point and assisted with screening requirements. The facility's Emergent Infectious Disease Preparedness Plan, adopted 2/2019, documented the following: *To prevent risk of spreading disease in the facility, staff were screened for exposure risk and signs and symptoms of disease before they reported to work. * Staff screening prohibited sick staff members from work until cleared by appropriate medical authorities. The CDC Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19, dated 5/8/20, stated, HCP should self-monitor when they are not at work and be actively screened upon entering the facility. These facility policies and CDC guidelines were not followed. The facility's employee screening logs and timesheets, dated 8/1/20 through 8/2/20 were reviewed for all employees of the facility. There were inconsistencies between the timesheets and staff screening logs. a. The following staff were not screened prior to working their shift. * The screening logs and timesheets, dated 8/1/20, did not include screening for 1 CNA, 1 Housekeeper, and 1 Dietary Staff. * The screening logs and timesheets, dated 8/2/20, did not include screening for 1 Housekeeper and 2 Dietary Staff. b. The facility's employee screening logs included a section to document the employee's temperature, and 10 yes/no questions related to symptoms associated with COVID-19. At the top of the screening logs there was a statement that directed employees to notify supervisor for further guidance for any 'Yes' responses. There was no documentation of action taken when employees answered yes to potential symptoms of COVID-19 for the staff as follows: * The screening logs and timesheets, dated 7/30/20, documented 1 CNA worked when she answered yes to questions of symptoms associated with COVID-19. * The screening logs and timesheets, dated 8/1/20, documented 1 RN and 1 Dietary Staff worked and their symptom evaluations on the screening log were blank. * The screening logs and timesheets, dated 8/2/20, documented 1 LPN and 1 RN worked when they answered yes to questions of symptoms associated with COVID-19. On 8/4/20 at 1:10 PM, Activity Aide #1 stated there was no protocol for the screening process. She stated that she called the IP or another nurse if she had a concern about anyone who entered with symptoms. When asked for documentation that a nurse was notified and evaluated the symptoms, Activity Aide #1 stated it was done verbally on an as needed basis, and there was no documentation. On 8/4/20 at 2:35 PM, the DON and IP were interviewed together, and the DON stated there was no tracking method for symptoms. The IP stated she reviewed the screening log daily, but she did not sign it. The IP stated there was no documentation and no policy for evaluating staff or visitors. She stated there was no written process to support the evaluation of employees or visitors. On 8/4/20 at 2:42 PM, the Administrator stated the facility did not have documentation they were screened further for COVID-19 symptoms. 2. The facility's Hand Hygiene Policy, dated 4/2019, documented situations which required hand hygiene included before and after direct resident contact, before and after handling food, and after handling soiled equipment. This policy was not followed. a. On 8/3/20 at 12:05 PM, CNA #1 was in Resident #1's room and using her bare hands picked up Resident #1's fall mat and moved it aside. CNA #1 did not perform hand hygiene after moving the fall mat with her bare hands. CNA #1 then moved a stool closer to the bed and moved Resident #1's bedside table. She assisted Resident #1 to get a drink of water and to adjust her in her bed. CNA #1 did not perform hand hygiene after moving the furniture, before touching Resident #1, and after touching Resident #1. CNA #1 then moved the bedside table and stool away from the bed, returned the fall mat to its prior position on the floor, and then she washed her hands. On 8/3/20 at 12:48 PM, CNA #1 said she adjusted Resident #1 in her bed and held a cup of water for her to drink after she touched the fall mat on the floor. CNA #1 said she did not perform hand hygiene after touching Resident #1's fall mat or before touching Resident #1 and her items. On 8/3/20 at 5:00 PM, the IP said CNA #1 should have performed hand hygiene after touching the floor mat. b. On 8/3/20 at 12:50 PM, CNA #4 exited a resident's room who had a sign on their door indicating Special Droplet/Contact Precautions were in place She was not wearing gloves, and she removed her face shield and sprayed it with a pink disinfectant spray. She wiped off the face shield, and then she did not perform hand hygiene. CNA #4 then walked down the hall to room [ROOM NUMBER], where Resident #2 was sitting in her wheelchair outside the room. CNA #4 did not perform hand hygiene, and she placed both of her hands on the handles on Resident #2's wheelchair and moved her a short distance down the hall. On 8/3/20 at 1:02 PM, CNA #4 said she should have performed hand hygiene after she wiped off her face shield and before she touched Resident #2's wheelchair. On 8/3/20 at 5:05 PM, the IP said staff should perform hand hygiene after exiting a resident's room and after removing their face shield and mask. 3. The facility's policy for Environmental Cleaning, dated 1/19/19, documented The environment throughout the facility will be maintained in a state of cleanliness that meets professional standards to protect residents and healthcare personnel from potentially infectious microorganisms. This policy was not followed. On 8/3/20 at 1:05 PM, CNA #2 came out of a resident room with a Hoyer lift (a mechanical lift). CNA #2 placed the Hoyer lift against the wall across the hall, then entered another resident's room. CNA #2 did not sanitize the Hoyer lift after using it with a resident. On 8/3/20 at 1:33 PM, CNA #2 said the protocol for sanitizing the Hoyer lift was to spray it down after it was used. CNA #2 said the Hoyer lift should be sanitized in the hall. CNA #2 said he did not sanitize the Hoyer lift after using it in room [ROOM NUMBER]. On 8/3/20 at 5:00 PM, the IP said the Hoyer lifts were to be disinfected between residents. 4. The facility's policy for Coronavirus COVID-19, revised 7/28/20, documented the following steps to be taken for Special Droplet/Contact Precautions, including: * Special Droplet/Contact Precautions were implemented for residents with suspected or confirmed COVID-19. * After performing hand hygiene, staff were directed to don PPE, including a mask or a respirator. The CDC website, accessed 8/5/20, stated when putting on a respirator, do not allow anything to prevent proper placement or to come between your face and the respirator. The facility policy and CDC guidance were not followed. On 8/3/20 at 3:34 PM, CNA #3 prepared to enter room [ROOM NUMBER] which had a sign posted on the door indicating Special Droplet/Contact Precautions were in place. The sign directed everyone who entered the room to wear a face mask, when they entered the room. CNA #3 donned a gown and gloves, and she was already wearing a face shield and an N-95 mask over a blue procedure mask. CNA #3 then entered the room with a bag of adult briefs. CNA #3 exited the room, and she was wearing an N-95 mask and face shield, she was not wearing the face mask under the N-95 mask. CNA #3 said staff were to put on PPE including a gown, gloves, N-95 mask, and face shield prior to entering room [ROOM NUMBER]. CNA #3 said after she entered the room, she removed the blue face mask by pulling it off underneath the N-95 mask. She stated she disposed of it in the room because there was no trash can outside the room where she could dispose of it. On 8/3/20 at 4:55 PM, the IP said staff should remove their blue face mask prior to entering a resident's room, because pulling the blue mask off underneath the N-95 mask would break the seal of the N-95 mask. 5. The facility's Coronavirus COVID-19 policy, updated 7/28/20, documented during a COVID-19 outbreak, staff would wear a face shield upon entrance to the facility for the duration of their shift. It also documented all staff would use face masks and

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) face shields when working in the facility. The CDC website, accessed 8/5/20, stated eye protection is to be worn upon entry to the patient care area. This facility policy and CDC guideline were not followed. On 8/3/20 at 11:26 AM, RN #1 was observed in the COVID-19 isolation unit wearing a surgical mask. She did not have a face shield on. When asked if it was the facility's policy to wear only a surgical mask, RN #1 said no she should also have a face shield on. On 8/3/20 at 2:35 PM, the IP stated staff should wear a mask and face shield in the COVID-19 Isolation Unit. On 8/4/20 at 4:02 PM, the Administrator, IP, and DON were informed of an Immediate Jeopardy determination for 42 CFR 483.80 (F880) via phone, and the Immediate Jeopardy template was subsequently sent via fax.