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 _____	10/16/2020

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were consistently 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. The CDC's website, accessed on 10/19/20, Preparing for COVID-19 in Nursing Homes: Managing New Admissions and Readmissions Whose COVID-19 status was Unknown stated health care personnel should wear an N95 or higher level respirator (or facemask if a respirator was not available), eye protection (goggles of face shield), gloves and gown when caring for these residents. This guidance was not followed: The facility's B Hall had the COVID-19 negative residents as well as residents under observation for signs and symptoms of COVID-19. a. On 10/15/20 at 9:40 AM, Resident #1's room was observed to have a PPE cart and a STOP sign which was adapted from a hospital association posted outside of her room. The signage stated Quarantine Precautions in addition to Standard Precautions. Everyone must: *Clean hands when entering and leaving the room. *Wear mask. *Wear eye protection. *Gown and glove when providing direct resident care. On 10/15/20 at 10:25 AM, CNA #1 wearing a facemask and a face shield knocked on Resident #1's room. When CNA #1 entered Resident #1's room, a male staff wearing a facemask and a face shield was observed sitting on the chair and talking to Resident #1. On 10/15/20 at 10:27 AM, CNA #1 exited Resident #1's room. CNA #1 said she did not wear a gown because she just answered Resident #1's call light. CNA #1 said Resident #1 requested a cup of coffee and she turned her call light off. When asked who the male staff Resident #1 was talking to, CNA #1 said it was the LSW. On 10/15/20 at 11:32 AM, the LSW said Resident #2 who was the roommate of Resident #1 had a positive COVID test and was transferred to the COVID unit that morning. LSW said he informed Resident #1 that she would be transferred to another room for observation for 14 days. The LSW said she did not wear a gown because he just talked to Resident #1. b. On 10/15/20 at 12:33 PM, CNA #2 wearing a facemask and a face shield delivered the food tray of Resident #9. Resident #9 had a STOP sign and a PPE cart outside his door. CNA #2 did not wear a gown or gloves when she entered Resident #9's room. When CNA #2 exited Resident #9's room she performed hand hygiene. CNA #2 then took a cup of drink from the meal cart and entered Resident #10's room. On 10/15/20 at 12:40 PM, CNA #1 she did not wear a gown or gloves when she delivered the food tray of Resident #9. CNA #1 said she would wear gown if she was going to provide direct care to Resident #9. On 10/15/20 at 1:55 PM, the DON with the IP said the facility's new admissions were placed in observation unit for 14 days. When asked what type of precautions they require to their newly admitted residents, the DON said the residents were placed on quarantine transmission based precautions. The DON said all facility's newly admitted residents and residents on [MEDICAL TREATMENT] were placed on droplet precautions and staff would use contact precautions when they provide direct personal cares to the residents. The DON said staff wore facemask and a face shield, and gowns and gloves were required when they provide personal cares to the resident under observation for signs and symptoms of COVID-19. The DON said gowns and gloves were not needed to be worn by staff if they were just going to talk to these residents or delivered their food trays. The DON said the signage was provided to them by their corporate office and being used by all their facilities. 2. The facility's Hand Hygiene policy and procedure, revised April 2019, directed staff to assist residents with hand hygiene before and after their meals. This policy was not followed: On 10/15/20 from 12:20 PM to 12:25 PM, lunch trays were being delivered to the residents. The following was observed in the B Hall - at 12:20 PM, CNA #3 delivered Resident #3's food tray and placed it on her overbed table and left the room. CNA #1 did not offer hand hygiene to Resident #3 before eating her meal. - at 12:22, CNA #3 delivered Resident #5's food tray and placed it on her overbed table and left the room. CNA #3 did not offer hand hygiene to Resident #5 before eating her meal. - at 12:25, CNA #3 delivered Resident #6's food tray and placed it on her overbed table and left the room. CNA #3 did not offer hand hygiene to Resident #6 before eating her meal. ON 10/15/20 at 12:45 PM, Resident #5 said she was not offered hand hygiene before eating her meals. On 10/15/20 at 1:00 PM, CNA #1 said Residents #3, #5 and #6 were capable of washing their hands. When asked if he ask the residents if they had washed their hands when he delivered their food trays, CNA #1 said he No. On 10/15/20 at 1:05 PM, the IP with the DON present said hand hygiene should be offered to the residents before and after eating their meals. The DON said staff would not offer hand hygiene to the residents if they knew they were independent and can wash their hands. b. Resident #8's MDS, dated [DATE], documented Resident #8 was moderately impaired, and required limited 1-person physical assistance when eating. Resident #7's MDS, dated [DATE], documented Resident #7 was cognitively severely impaired, and required encouragement and cueing when eating. On 10/15/20 at 12:17 PM, Resident #7 and Resident #8 were observed sitting in wheelchairs in the TV lobby before lunch, then were wheeled into the dining room by CNA #4 and placed in front of two tables. CNA #4 placed a lunch tray and beverages in front of each resident and the residents began to feed themselves. On 10/15/20 at 12:19 PM, CNA #4 said she did not offer or provide Resident #7 or Resident #8 with hand hygiene before they ate their meals. On 10/15/20 at 1:55 PM, The IP said the residents should be reminded or offered hand hygiene before eating. On 10/15/20 at 1:56 PM, the DON said the residents should always be encouraged to wash their hands and offered hand hygiene before meals. The DON said staff would not offer hand hygiene if they knew the resident perform their own self-care and always washed their own hands.

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.