

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/04/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>KARCHER POST-ACUTE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
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E 000	<p>Initial Comments</p> <p>A COVID-19 Focused Emergency Preparedness Survey was conducted from August 3, 2020 through August 4, 2020. The facility was found to be in compliance with CFR §483.73 related to E-0024 (b)(6).</p> <p>The survey was conducted by:</p> <p>Cecilia Stockdill, RN, Team Coordinator Kim Saccomando, RN Sallie Schwartzkopf, LCSW</p>	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/27/2020

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 000	INITIAL COMMENTS  The following deficiency was cited during a COVID-19 Focused Infection Control survey which was conducted from August 3, 2020 through August 4, 2020  The survey was conducted by:  Cecilia Stockdill, RN, Team Coordinator Kim Saccomando, RN Sallie Schwartzkopf, LCSW  Survey Abbreviations:  CDC = Centers for Disease Control and Prevention CNA = Certified Nursing Assistant DON = Director of Nursing IP = Infection Preventionist PPE = Personal Protective Equipment	F 000			
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		9/10/20	

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F 880	<p>Continued From page 1</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents</p>	F 880			

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F 880	<p>Continued From page 2 identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: 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:</p> <p>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.</p> <p>The facility's Emergent Infectious Disease Preparedness Plan, adopted 2/2019, documented the following:</p> <p>*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</p>	F 880	<p>F880 - 1. Screening for signs and symptoms No specific residents affected All residents in the center will be monitored for signs and symptoms of Covid-19 to ensure ongoing health status. Employee's entering the center will be screened using the employee screening tool prior to reporting for work. Screening will be conducted by designated center personnel and follow up will be completed for employees who answer in the affirmative for possible signs/symptoms prior to entering the center. New assessment form has been initiated to assist with determining if staff members who have affirmative answers to signs/symptoms are able to enter facility to work or are to be sent home. If after licensed nurse assessment the reason for symptoms is unknown or are unable to be determined, employee will be sent home and work restrictions applied. Education provided to screeners on appropriate screening process and need for assessment form for affirmative</p>		

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F 880	<p>Continued From page 3</p> <p>from work until cleared by appropriate medical authorities.</p> <p>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."</p> <p>These facility policies and CDC guidelines were not followed.</p> <p>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.</p> <p>a. The following staff were not screened prior to working their shift.</p> <p>* The screening logs and timesheets, dated 8/1/20, did not include screening for 1 CNA, 1 Housekeeper, and 1 Dietary Staff.</p> <p>* The screening logs and timesheets, dated 8/2/20, did not include screening for 1 Housekeeper and 2 Dietary Staff.</p> <p>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."</p> <p>There was no documentation of action taken when employees answered "yes" to potential</p>	F 880	<p>answers. Schedules will be cross checked with the screening log to ensure that all staff members have been screened. This will be verified by the DNS/designee. Staff have been educated about the screening process and new assessment tool.</p> <p>Audits cross checking schedule to screening log will be conducted by DNS/designee 5 days a week x 30 days, then decreased to 2 x a week x 2 months to ensure ongoing compliance. Continued education will be provided around any discrepancies found. Center Administrator/designee will validate screening is completed for scheduled employees cross checking screening log and employee timesheets daily 5 days a week x 30 days, then decreased to 2 x a week x 2 months to ensure ongoing compliance. Results of audits will be presented and reviewed in QAPI monthly for 3 months.</p> <p>Date of Compliance will be September 10th, 2020</p> <p>DNS/designee will be responsible for ongoing compliance</p> <p>F880 - 2. Hand Hygiene Resident #1 and Resident #2 have had no adverse illness based on this incident No other residents were affected by this incident. Hand Hygiene will be observed to prevent potential source of contamination. In-service/Re-education and policy and procedure provided for staff regarding hand hygiene. This will include the review of need for hand hygiene prior to resident</p>		

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F 880	<p>Continued From page 4</p> <p>symptoms of COVID-19 for the staff as follows:</p> <ul style="list-style-type: none"> <li>* 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.</li> <li>* 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.</li> <li>* 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.</li> </ul> <p>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.</p> <p>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.</p> <p>On 8/4/20 at 2:42 PM, the Administrator stated the facility did not have documentation they were</p>	F 880	<p>contact, after touching dirty items, cleaning items, i.e.: face shields and in-between resident contact. Three to five staff members will be audited/observed daily 5 days a week x 1 month, then 3 x a week x 2 months to ensure ongoing compliance. Results of audits and observations will be presented and reviewed in QAPI monthly for 3 months. Date of Compliance will be September 10th, 2020 DNS/designee will be responsible for ongoing compliance.</p> <p>F880 - 3. Environmental Cleaning No specific resident affected No other residents were affected by this incident. Environmental cleaning of equipment i.e.: Hoyer lift will be cleaned between uses to prevent a potential source of contamination. In-service/Re-education and policy and procedure for equipment cleaning will be provided for staff. This will include the policy and procedure for Standard Precautions dated 3/2020 Random audit/observations will be conducted daily 5 days a week x 1 month then 3 x a week x 2 months to ensure ongoing compliance. Results of audits and observations will be presented and reviewed in QAPI monthly for 3 months Date of Compliance will be September 10th, 2020 DNS/designee will be responsible for ongoing compliance</p> <p>F880 - 4. Special Droplet/Contact</p>		

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F 880	<p>Continued From page 5 screened further for COVID-19 symptoms.</p> <p>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.</p> <p>This policy was not followed.</p> <p>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.</p> <p>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.</p> <p>On 8/3/20 at 5:00 PM, the IP said CNA #1 should have performed hand hygiene after touching the floor mat.</p> <p>b. On 8/3/20 at 12:50 PM, CNA #4 exited a</p>	F 880	<p>Precautions - Proper usage of masks No specific resident affected No other residents were affected by this incident. Staff will use and wear face coverings in accordance with policy to prevent potential for spreading disease processes. In-service/Re-education provided to nursing staff about proper usage of face coverings. Education will included proper fit for N95 masks prior to entering room that required such face covering. Three to five staff members will be audited/observed daily 5 days a week x 1 month, then 3 x a week x 2 months when N95 masks are in use. Results of audits and observations will be presented and reviewed in QAPI monthly for 3 months Date of Compliance will be September 10th, 2020 DNS/designee will be responsible for ongoing compliance</p> <p>F880 - 5. Use of face shield No specific resident affected. No other residents were affected by this incident. No residents currently on Covid unit. In-service/Re-education and review of policy and procedure on wearing face shield/eye protection while in the center to be conducted for staff. This is in conjunction with the CDC guidelines for using eye protection in nursing facilities. Three to five staff members will be audited/observed daily 5 days a week x 3 months. This will be done during daily rounding by DNS/designee. Re-education will be provided for any staff that is</p>		

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F 880	<p>Continued From page 6</p> <p>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 #541, 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.</p> <p>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.</p> <p>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.</p> <p>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."</p> <p>This policy was not followed.</p> <p>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.</p>	F 880	<p>non-compliant until policy and procedure is changed based on CDC recommendations. Results of the daily observation will be presented and reviewed at QAPI monthly for 3 months Date of Compliance will be September 10th, 2020 DNS/designee will be responsible for ongoing compliance</p>		

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F 880	<p>Continued From page 7</p> <p>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 #585.</p> <p>On 8/3/20 at 5:00 PM, the IP said the Hoyer lifts were to be disinfected between residents.</p> <p>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:</p> <ul style="list-style-type: none"> <li>* Special Droplet/Contact Precautions were implemented for residents with suspected or confirmed COVID-19.</li> <li>* After performing hand hygiene, staff were directed to don PPE, including a mask or a respirator.</li> </ul> <p>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.</p> <p>The facility policy and CDC guidance were not followed.</p> <p>On 8/3/20 at 3:34 PM, CNA #3 prepared to enter room 545 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</p>	F 880		

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F 880	<p>Continued From page 8</p> <p>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.</p> <p>CNA #3 said staff were to put on PPE including a gown, gloves, N-95 mask, and face shield prior to entering room 545. 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.</p> <p>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.</p> <p>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 face shields when working in the facility.</p> <p>The CDC website, accessed 8/5/20, stated eye protection is to be worn upon entry to the patient care area.</p> <p>This facility policy and CDC guideline were not followed.</p> <p>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</p>	F 880			

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NAME OF PROVIDER OR SUPPLIER  <b>KARCHER POST-ACUTE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 9</p> <p>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.</p> <p>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.</p> <p>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.</p>	F 880			