



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER - Governor  
RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1886

**CERTIFIED MAIL: 7007 3020 0001 4038 9765**

November 6, 2014

Brent Schneider, Administrator  
Karcher Estates, Llc  
1127 Caldwell Boulevard,  
Nampa, ID 83651-1701

FILE COPY

Provider #: 135110

Dear Mr. Schneider:

On **October 29, 2014**, we conducted an on-site follow-up revisit to verify that your facility had achieved and maintained compliance. We had presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **September 24, 2014**. However, based on our on-site follow-up revisit conducted **October 29, 2014**, we found that your facility is not in substantial compliance with the following participation requirements:

- C0784 -- S/S: -- 02.200,03,b -- Resident Needs Identified**
- F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being**
- F0332 -- S/S: D -- 483.25(m)(1) -- Free Of Medication Error Rates Of 5% Or More**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column X5 Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Brent Schneider, Administrator  
November 6, 2014  
Page 2 of 3

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 18, 2014**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the letter of **July 29, 2014**, following the **Recertification, Complaint Investigation and State Licensure** survey of **July 11, 2014**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **January 11, 2015**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Brent Schneider, Administrator  
November 6, 2014  
Page 3 of 3

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option #2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

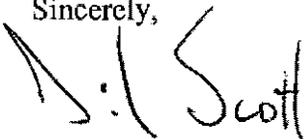
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **November 18, 2014**. If your request for informal dispute resolution is received after **November 18, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the on-site follow-up revisit. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



David Scott, RN, Supervisor  
Long Term Care

DJS/pmt  
Enclosures

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

PRINTED: 11/05/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 10/29/2014
NAME OF PROVIDER OR SUPPLIER  KARCHER ESTATES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651	
(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 000}	INITIAL COMMENTS  The following deficiencies were cited during the follow-up to the annual federal recertification survey of your facility.  The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP, Team Coordinator Amy Barkley, RN, BSN,  The survey team entered the facility on October 29, 2014 and exited on October 29, 2014.  Survey Definitions: CP = Care plan DON = Director of Nursing Services LN = Licensed Nurse MG = Milligram	{F 000}	RECEIVED NOV 13 2014 FACILITY STAFF	
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure Resident #6's care plan was followed to adjust the bed to its lowest position. In addition, the facility failed to follow its plan of correction, specifically the resident was to be assessed by a	{F 309}	-The identified resident, #6 had her bed adjusted to the lowest position on 10-29-14. The facility physical therapist assessed the resident on 10-30-14 to determine her ability to get in and out of a low bed and if the resident is appropriate for a low bed. It was determined the resident is appropriate for the low bed.  -All residents have the potential to be affected by this deficient practice. All residents who require the bed to be in the lowest position have been identified, assessed, and care planned to address this concern. Staff checked each resident and made sure the bed was in the lowest position for safety.  -The Restorative Nurse will monitor all residents who require a low bed to make sure that resident has been assessed by a physical therapist for the appropriateness of using a low bed, that the results of the physical therapy assessment are placed in the patient's chart, that the intervention of a low bed is documented on the care plan, that staff are following the care plan and the resident's bed is in the lowest position while they are in the bed, that the assessment was repeated by	

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

*[Signature]* Administrator 11-18-14

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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(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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 309}	Continued From page 1 "Physical Therapist quarterly and as needed." Failure to assess the resident's ability to get in and out of a low bed put the resident at increased risk to fall, creating a potential for harm. Findings include:  Resident #6 was admitted to the facility on 10/24/10 and readmitted on 8/11/11 with diagnoses which included senile dementia, muscle weakness and adult failure to thrive.  Resident #6's 12/26/13 Care Plan for Falls due to weakness included an intervention to, "Keep my bed in the lowest position when I am in it."  On 10/29/14 the resident was observed during the follow-up survey to be out of bed while the surveyors were in the facility.  Review of the resident's medical record and QA audits provided to the surveyors revealed the resident's bed was not in the low position on 9/30/14, which was after the date of compliance. The administrator was asked for the Physical Therapy assessment for Resident #6. On 10/29/14 at 3:15 p.m., the administrator informed the survey team the therapists had not completed the assessment. No further information was provided.	{F 309}	-Continued the physical therapist and documented, and any recommendations as a result of the assessment were added to the care plan. This review will be on going and a part of the Restorative Nurse's responsibilities. All residents with a low bed will be discussed quarterly at the quality assurance meeting to evaluate the continued need of the low bed as well as the resident's safety. -The Restorative Nurse will monitor the compliance of the plan of correction by reviewing all residents who require a low bed to make sure that resident has been assessed by a physical therapist for the appropriateness of using a low bed, that the results of the physical therapy assessment are placed in the patient's chart, that the intervention of a low bed is documented on the care plan, that staff are following the care plan and the resident's bed is in the lowest position while they are in the bed, that the assessment was repeated by the physical therapist and documented, and any recommendations as a result of the assessment were added to the care plan. This monitoring will occur weekly x4 weeks and monthly x3 months beginning 11-10-14. The results of the monitoring will be reported to the monthly QA meeting for 3 months. The Administrator, DNS, and Restorative Nurse will be responsible to ensure that all residents with a low bed are audited and they receive a low bed assessment by the Physical Therapist. Completion date: 11-14-14		
{F 332} SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced	{F 332}			

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NAME OF PROVIDER OR SUPPLIER  KARCHER ESTATES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
(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 332}	<p>Continued From page 2</p> <p>by:</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure 2 residents (#s 19 and 20) were free from medication errors. The failure created the potential for less than optimum benefit from prescribed medications when the medications were not administered as ordered. The facility's medication error rate was 9.0%. Findings include:</p> <p>1. Resident #20's Physician orders, dated 8/9/14, documented:</p> <ul style="list-style-type: none"> <li>- Omeprazole capsule, delayed release; 20 mg; oral special instructions: 30 - 60 minutes prior to meal for GERD (gastroesophageal reflux disease) once a Morning; 07:00.</li> </ul> <p>On 10/29/14 at 10:05 a.m., LN #1 was observed administering the medication to the resident.</p> <p>On 10/29/14 at 11:45 a.m., the DON was interviewed about the delayed administration of the medication and confirmed the medication should have been given prior to the resident eating breakfast.</p> <p>2. Resident #19's October 2014 Physician Recapitulation order, which was signed by the physician on 10/8/14, documented:</p> <ul style="list-style-type: none"> <li>- Torsemide tablet; 100 mg; oral once a morning.</li> </ul> <p>On 10/29/14 at 10:10 a.m., LN #1 was observed to administer one half of a 100 mg tablet to Resident #19.</p> <p>On 10/29/14 at 11:45 a. m., the DON was interviewed about LN#1 only giving half the physician prescribed dosage. The DON confirmed there was a problem with the</p>	{F 332}	<p>-The LN causing the Medication error on resident #20 has been re-educated and counseled to administer medications at the prescribed times.</p> <p>-Resident #20 was assessed and no adverse effects were found as a result of the medication error. The MD was notified and no new orders were given. Resident #19 has been assessed and no adverse effects were found as a result of the medication error. The MD and family of resident #19 has been notified. The MD wrote orders for Torsemide 50mg daily.</p> <p>-All residents have the potential to be affected by this deficient practice. All residents receiving medications have been assessed to make sure they are receiving their medications according to physician orders including correct time of administration and correct dose.</p> <p>-The facility has designated 2 nurses to assess the recaps and the medication sheet for correctness prior to the change-over of medication sheets at the end of the month. They will be assigned to perform this review routinely at the end of the month.</p> <p>-The night nurse, prior to the change-over of the medications sheets, will review the medication sheets for any additional medications that were ordered for the last few days of the month and add them to the new medication sheet for the up-coming month. This will serve as an additional check of correctness of the MARs</p>	

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NAME OF PROVIDER OR SUPPLIER  KARCHER ESTATES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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{F 332}	Continued From page 3 medication dosage and its administration.  On 10/29/14 at 3:30 p.m., the administrator and DON were informed of the issues. No further information was provided.	{F 332}	<p>-Continued</p> <p>-The shift to shift report sheet will be revised to list all residents that receive 7 am medications. This will ensure that the LN's are aware of all residents that take medications before meals.</p> <p>-All LN's had an in-service on 11/5/14 on Medication administration and prevention of Medication errors.</p> <p>-A new medication error form will be implemented to track medication errors in the facility. The DNS will investigate each medication error.</p> <p>-To help decrease all medication errors in the building all LN will have a medication pass audit by the Staff Development Nurse and will have annual Medication pass audits with their annual evaluations. The Staff Development Nurse will monitor a sample of medications passes to make sure the medications are being administered according to physician orders especially the correct time and correct dose. This audit will occur weekly X 4 weeks and monthly X 3 months beginning 11-11-14. The results of the monitoring will be reported to the monthly QA meeting for three months.</p> <p>-The Administrator and the DNS will be responsible to ensure that all nurses are following the proper procedure of Medication administration.</p> <p>-Completion date: 11-14-14</p>	

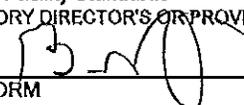
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 10/29/2014
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NAME OF PROVIDER OR SUPPLIER  KARCHER ESTATES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651
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{C 000}	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the annual state survey of your facility.  The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QMRP, Team Coordinator Amy Barkley, RN, BSN,  The survey team entered the facility on October 29, 2014 and exited on October 29, 2014.	{C 000}		
{C 784}	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F309 as it relates to care.	{C 784}	Refer to Plan of Correction F309	11-14-14

RECEIVED  
NOV 13 2014  
FACILITY STANDARDS

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11-18-14
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