IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 4, 2015

Benjamin Roedel, Administrator
Karcher Estates
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Roedel:

On **November 20, 2015,** a survey was conducted at Karcher Estates, Llc by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided 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. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) 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 the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 17, 2015**. Failure to submit an acceptable PoC by **December 17, 2015**, may result in the imposition of civil monetary penalties.

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; and
- 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 6, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 6, 2016**. A change in the seriousness of the deficiencies on **January 6, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 6, 2016** includes the following:

Denial of payment for new admissions effective **February 20, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 20, 2016**, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 20, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. 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 **December 17, 2015**. If your request for informal dispute resolution is received after **December 17, 2015**, 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 survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

D. Scott for N.S.

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 federal recertification and complaint survey conducted at the facility from November 16 to November 20, 2015. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Presie Billington, RN Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cc = cubic centimeters CNA = Certified Nurse Aide DNS = Director of Nursing Services IV = Intravenous LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PICC = Peripherally Inserted Central Catheter PRN = As Needed	F 000	**Preparation or execution of Plan of Correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies.** **The Plan of Correction is prepared and or executed solely because law requires it.** RECEIVED DEC 17 2015 FACILITY STANDARDS	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167	F 167 - This deficient practice has the potential to affect 51 residents and visitors. The survey result binder was updated on day of discovery 11/16/2015. The administrator or designee will monitor weekly x 1 month and monthly x 3 months to assure compliance. The results of monitoring will be reported monthly x 3 months to QA committee.	11/16/2015

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

R H R — Executive Director — 12/17/15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 167	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure the results of the most recent survey were readily accessible to residents. This deficient practice was true for any resident or their representative who may want to review the survey results, including 12 of 12 sample residents (#s 1-12). Findings included: On 11/16/15 at 10:20 AM, survey results binders were observed on the walls near the main entrance and the residents' dayroom. Inside the binders were the last annual recertification survey, dated 7/11/14. The results of the onsite follow-up survey of 10/29/14 were not located in either binder. On 11/16/15 at 10:40 AM, the DNS said she did not see the 10/29/14 survey results in the binders.	F 167		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents who self-administered medication were assessed by the Interdisciplinary Team and determined to be safe to do so. This was true for 1 of 13 residents (#18) observed	F 176	F 176 - This deficient practice of not assessing residents for their ability to self-administer medications has the potential to affect 51 residents. Resident #18 was assessed for physical and mental ability to self-medicate, and was determined to be unable to administer his own medications. Nebulizer treatments will be administered under supervision of nursing staff. The nursing staff was in-serviced on 11/17/2015 regarding facility procedure for	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 176	Continued From page 2 during medication passes. Failure to provide all of Resident #18's DuoNeb medication via nebulizer created the potential for sub-optimal respiratory care which could contribute to exacerbation of COPD (chronic obstructive pulmonary disease). Findings included: On 11/17/15 at 9:55 am, Resident #18 was observed alone in his room when LN #2 set-up the resident's DuoNeb nebulizer treatment, turned on the nebulizer machine, handed the acorn (reservoir with medication) with a mouthpiece to the resident and told the resident she would be back in "ten minutes." The LN then left the resident's room. LN #2 and the surveyor returned to Resident #18's room at 10:12 am. CNAs #4 and #5 and the resident's roommate were in the room. The nebulizer machine was observed to be off and the acorn/mouthpiece was on top of the nebulizer machine. LN #2 picked up the acorn and said there was still medication in it. The LN turned on the nebulizer and was about to hand the acorn/mouth piece to the resident when the resident's roommate said the resident needed to go in the restroom and brush his teeth. The CNAs proceeded to assist Resident #18 into the restroom and LN #2 left the room. Immediately afterward, LN #2 was asked if Resident #18 had been assessed to self-administer the DuoNeb medication. The LN said she did not know. The LN then reviewed Resident #18's medical record and said she did not find a medication self-administration assessment for DuoNeb. The LN added that the resident had returned to the facility "10 days ago" from a hospital stay for "respiratory problems."	F 176	administration of inhalation medications and nebulizer treatments. Additional nursing education regarding self-administration of medications, and nebulizer procedures, will be completed by 12/31/2015. Policies and procedures for self-administration of medications, nebulizer treatments, and inhaler medications were developed and will be implemented by 12/31/2015. Unit managers will monitor for compliance to assure all medications are administered according to MD order and facility procedures. This monitoring will occur weekly and will be reported to DON or designee, and reported monthly to QA x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 176	Continued From page 3 The resident's facility Physician Order Report, dated 11/1/15-11/30/15, included an order for ipratropium-albuterol solution for nebulization every 6 hours "as needed" (PRN) for asthma/COPD, also dated 11/6/15. Refer to F 514 regarding medical record accuracy. Resident #18 was still in the restroom when LN #2 and the surveyor returned to his room at 10:20 am. The LN then reviewed the resident's medical record again and said that she did not find a medication self-administration assessment. On 11/17/15 at 10:40 am, the door to Resident #18's room was open and a nebulizer machine was heard running. From the doorway, the resident was observed dozing in his recliner with the nebulizer acorn/mouthpiece in his hand in his lap. There were no LNs in the resident's room nor in the vicinity of the resident's room.	F 176	12.29.15 11:30 A.m. Spoke with Administrator. Part of the process will be to interview affected residents, if interviewable, to ask if staff knock before entering their rooms. KM	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to respect residents' private space when staff entered residents' rooms without knocking. This was true for 2 of 12 (#s 4 & 5) sampled residents and 5 (#s 15-17, 22, & 23) random residents residing in the facility. This	F 241	F 241 - Failure to respect the residents' dignity and respect of individuality by not knocking had the potential to affect 51 residents. All staff will be in-serviced on promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Specific training will be given on knocking when entering resident's room to respect private space by December 31, 2015. Random audits for compliance will be conducted at least weekly for one month, then monthly for three months by the staff	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 241	Continued From page 4 failed practice created the potential for residents to experience a lack of respect for privacy. Findings included: Staff were observed entering resident rooms without knocking as follows: a. On 11/16/15 at 2:05 PM, Unit Manager #1 (UM) was observed walking into Resident #5 and resident #15's shared room without knocking. Both residents were in bed at the time. UM #1 did not announce himself until he stood next to Resident #5's bed and asked the resident a question. On 11/16/15 at 2:10 PM, UM #1 acknowledge he forgot to knock. b. On 11/16/15 at 2:30 PM, CNA #9 was observed walking into Resident #4 and resident #16's shared room and did not knock or announce herself. Both residents were in the room at the time. On 11/16/15 at 2:31 PM , CNA #9 said she had not gone into the room to provide resident care, so she did not need to knock. c. 11/17/15 at 9:30 am - LN #2 did not knock or announce herself when she entered Resident #17's room and awakened the resident. When informed of the observation, the LN said she had not knocked or announced herself before entering the resident's room. d. 11/17/15 at 2:20 pm - LN #3 did not knock or announce herself when she entered Resident #22's room. When informed of the observation, the LN said she had not knocked or announced	F 241	development nurse. Audit results will be reported to DON or designee weekly, and to QA monthly times 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 241	Continued From page 5 herself before entering the resident's room. e. 11/19/15 at 11:55 am, LN #10 checked Resident #23's blood glucose level then left the room. The LN did not knock or announce herself when she returned to the resident's room at 12:07 pm. When informed of the observation, the LN said, "I figured she knew we were coming back."	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to revise care plan for 1 of 14 (#1) sampled residents. Resident	F 280	F 280 - Failure to update care plan has the potential to affect 51 residents. Resident #1 has had her care plan updated to include the specific blood glucose order change, which was cited. Nursing staff will be educated by 12/31/ 2015 regarding the facility procedure for follow through of physician orders to care plans. Random care plan audits will be completed by RN weekend supervisor weekly times one month and monthly times three months, and reported to DON or designee. The DON will report to QA monthly for three months.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 280	Continued From page 6 #1's care plan was not revised regarding a physician order for blood glucose parameters. This had the potential to result in harm if Resident #1 did not receive appropriate care due to lack of direction in her care plan. Resident #1 was admitted to the facility on 9/24/15 with multiple diagnoses including diabetes mellitus and hypertension. Resident #1's care plan, dated 10/6/15, documented the physician was to be notified of any BG's [blood glucose levels] less than 70 mg/dl [milligrams per decaliter] or greater than 400 mg/dl. The resident's November 2015 Physician Order and TAR, documented a 9/24/15 order for staff to check blood glucose levels daily and if the blood glucose was below 80 mg/dl or greater than 400 mg/dl, then staff were to notify the resident's the physician. On 11/18/15 at 11:35 a.m., LN#3 compared the physician's order with the Care Plan [CP] and said the CP needed to be updated.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 2 of 2 residents (#18 and #19) rinsed their mouths after	F 281	F281—the deficient practice of not instructing residents to rinse their mouths after using corticosteroid inhalers has the potential to affect 7 residents. Residents #18 and #19 have medication sheets in place that reflect the monitoring of rinsing their mouth after the use of steroid metered dose inhalers. The nursing	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 281	Continued From page 7 administration of an inhaled corticosteroid medication during medication pass observations. The failure created the potential for the residents to develop oral candidiasis (thrush). Findings included: 1. On 11/17/15 at 9:55 am, LN #2 was observed as she administered two puffs of Symbicort (budesonide, a corticosteroid, and formoterol, a bronchodilator) to Resident #18. After that, the LN administered another inhaled bronchodilator, started the resident's breathing treatment, then left the room. The LN did not instruct or encourage the resident to rinse his mouth and spit out the water. In addition, the LN did not offer the resident any water after the inhaled corticosteroid was administered. On 11/17/15 at 12:22 pm, LN #2 said she "neglected" to have the resident rinse his mouth and spit after the inhaled corticosteroid medication was administered. Regarding Symbicort for inhalation, the Nursing 2016 Drug Handbook, Patient Teaching, included, "Rinse your mouth with water and then spit out the water after each dose to decrease the risk of developing oral candidiasis." 2. On 11/19/15 at 10:00 a.m., LN #10 was observed as she administered Resident #19's Advair (contained a corticosteroid component). The LN offered the resident a drink of water, which the resident refused. The LN did not instruct or encourage the resident to rinse her mouth and spit out the water. Immediately afterward, when informed of the observation, LN #10 stated, "No, I did not."	F 281	staff were in-serviced on 11/17/2015 to instruct residents to rinse their mouths with water and then spit out the water after each steroid metered dose inhaler use to decrease the risk of oral candidiasis. Nursing staff will be educated further by 12/31/ 2015, specifically about correct facility procedure for administration of metered dose inhalers. The unit managers will monitor nursing staff to assure compliance with inhaler procedures. This monitoring will take place weekly x 4, and monthly x 3. This will be reported to the DON or designee, and monthly x 3 to QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 281	Continued From page 8 Regarding Advair, the Nursing 2016 Drug Handbook, Patient Teaching, included, "Instruct patient to rinse mouth after inhalation to prevent oral candidiasis."	F 281		
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 staff interview and record review, it was determined the facility failed to follow physician orders to monitor heart rates prior to the administration medications, monitor fluid intake, and perform dressing changes as ordered. This was true for 3 of 12 (#'s 1, 8, and 12) sampled residents. These failures created the potential for harm if residents experienced complications related to unmet care needs. Findings included: 1. Resident # 1 was admitted to the facility on 9/24/15 with multiple diagnoses, including hypertension, atrial fibrillation and diabetes mellitus. The resident's recapitulated November Physician's Orders and Medication Administration Records (MAR) included an order for Metoprolol	F 309	F309—the deficient practice of not correctly providing care and services to residents has the potential to affect 51 residents. A new cardiac monitoring record for recording vital signs required for administration of antihypertensives and cardiac medications was created and implemented for resident #1, and will be implemented for all other residents receiving cardiac medications by 12/31/2015. The family and cardiac physician for Resident #8 was notified of the resident choosing to not follow fluid restrictions and her practice of obtaining her own fluids regularly, regardless of her restrictions. There are no other residents currently on fluid restrictions in the facility. Policy and procedures have been developed for monitoring fluid restrictions, and will include monitoring flow sheets. Resident #12 had his PICC line removed 11/18/2015, as had been scheduled prior to the findings. Policy and procedures have been formulated including a PICC line care and dressing flow sheet.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 309	Continued From page 9 tartrate 25 mg, twice daily, and staff were to hold the medication if the resident's systolic blood pressure was below 120 or the HR (heart rate) less than 60 beats per minute. Resident #1's November 1 through 18, 2015 MAR documented: * The resident received the morning dose of Metoprolol 18 times. The BP was documented but the HR was not. It was unknown if the resident's HR was less than 60 on 18 mornings the Metoprolol was administered. *The resident received the evening dose of Metoprolol 11 times and the medication was held 7 times because of a HR that was less than 60. The HR was not documented on the evenings Metoprolol was administered. Resident's BP and HR were both documented on 11/3/15 and on 11/16/15. 2. Resident #8 was admitted to the facility on 6/5/15, and readmitted on 10/26/15, with multiple diagnoses, including venous insufficiency, Methicillin Resistant Staphylococcus Aureus[MRSA] infection and heart failure. The resident's 11/13/15 Physician's Telephone Orders documented, "Fluid restrict[ion] 1,500 cc [cubic centimeters]/day." On 11/18/15 at 9:35 a.m., a glass of water was observed on the table inside Resident #8's room and within her reach. On 11/19/15 at 10:25 a.m., CNA #5 was interviewed about monitoring Resident #8's fluids. CNA #5 asked, "Is she in fluid restriction?" CNA #5 then went to another CNA, returned to the	F 309	Nursing staff will be educated by 12/31/2015 regarding providing quality care, specifically on monitoring vital signs for residents receiving cardiac medications, monitoring residents on restricted fluid intake, and new procedures for PICC line care and PICC dressing changes. The unit managers will monitor medication and treatment records weekly x 4 and monthly x 3 to assure cardiac vital signs are routinely obtained, to assure any residents on fluid restriction are having the restriction administered according to procedure, and to assure PICC dressing changes are timely and completed according to orders and facility procedure. The findings will be reported to DON or designee, and reported to QA committee monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 309	Continued From page 10 surveyor and said fluid intakes were monitored in the dining room and reported to the nurse on duty at the end of shift. On 11/19/15 at 10:45 a.m., LN #11 and the surveyor went to Resident #8's room and found a glass of water on the table filled with water above the 300cc mark. When asked how staff would know how much fluid the resident ingested while in her room, LN#11 said, "I don't know." She then took the glass of water out of the resident's room. 3. Resident #12 was admitted to the facility on 11/10/15 with multiple diagnoses, including, sepsis due to pseudomonas and diabetes mellitus. The resident's November 2015 Physician's Orders and TAR (Treatment Administration Record) documented: * IV/PICC Line Protocol: Change dressing every 4 days. Resident #12's TAR documented the PICC line dressing was changed on the fifth day (11/15/15) rather than on the fourth day (11/14/15) as physician ordered. On 11/18/15 at 3:45 pm, LN #3 was shown Resident #12"s TAR and said, "Dressing changes for other residents with PICC lines are done every five days, this could be just a typo. We always do the dressing every five days."	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following	F 328	F328 - The deficient practice of incomplet monitoring of oxygen saturation and titration for those who use oxygen could affect 12 residents who use oxygen in the facility.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 328	Continued From page 11 special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents who used oxygen:were monitored for oxygen saturation rates. This was true for 1 of 5 (# 1) residents sampled for oxygen and created the potential for harm should residents received oxygen therapy contrary to physician orders. Findings included: Resident #11 was admitted to the facility on 10/26/15 with multiple diagnoses, including heart failure. The resident's 10/27/15 Physician's Order documented oxygen was to be set at 0-4 LPM [liters per minute]continuous via NC [nasal cannula] to maintain blood-oxygen saturation levels above 90%. If levels fell below 89% then staff were to increase by the smallest amount possible up to 4 LPM and the physician was to be notified if saturations could not be maintained above 89% or 90% on 4 LPM. Bood-oxygen saturation levels were to be monitored every shift and as needed [PRN]. The November 2015 Shift Assignment Sheet	F 328	Resident #11 is no longer in the facility. Nursing staff will be educated by 12/31/2015 on o2 sat monitoring and titration according to procedure and MD orders. An updated policy and procedure, including a respiratory care sheet will be implemented for all residents on oxygen by 12/31/2015. Auditing to assure O2 sats are completed routinely for residents on O2 will be completed by unit managers weekly x 4, and monthly x 3 and reported to DON or designee. The audit findings will be reported to QA monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 328	Continued From page 12 documented Resident #11's O2 saturation levels were not monitored for 9 of 19 opportunities on the day shift and 15 of 18 opportunities on the evening shift. The resident was observed on the following occasions: * 11/18/15 at 2:40 PM: The resident was observed in bed with a NC on and the concentrator set at 4 LPM, * 11/19/15 at 8:25 AM: The resident was observed in the dining room in a wheelchair with a NC on and portable O2 set at 4 LPM, and, * 11/19/15 at 11:50 AM: The resident was observed in the hallway in a wheelchair with a NC on and portable O2 set at 2 LPM. On 11/19/15 at 11:15 AM, the DNS was said staff should have monitored and documented saturation levels each shift to make sure the resident received the correct amount of O2.	F 328		
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 by: Based on observation, interview, and record review, it was determined the facility failed to ensure its medication error rate was less than 5 percent. This was true for 2 of 25 medications for 2 of 13 residents (#s 20 and 21) during medication pass observations. The failure created the potential for residents to receive less	F 332	F332—the deficient practice of medication errors being greater than 5% has the potential to affect 51 residents. Nursing staff who work with Resident #21 have been in-serviced on the need to follow physician's orders precisely, including administering medications mixed with the correct amount of fluids as ordered. Resident #20's orders were updated to reflect the route of administration appropriate for recent changes in condition. The nursing staff will be in-serviced by 12/31/2015 on correct medication	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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	Continued From page 13 than optimum benefit when their medications were not administered as ordered or per pharmacy instructions. Findings include: 1. On 11/17/15 at 9:20 a.m., LN #2 was observed pouring 5 oral medications, including Miralax mixed in water, for Resident #21. Before the medications were administered, the LN was asked to mark the water line on the small plastic glass in which the Miralax was mixed. After the meds were administered, the LN was asked to measure how much water was used to mix to the Miralax. The LN poured water to the water line mark on the plastic glass and said she had used 4 ounces of water to mix the Miralax. The resident's Physician Order Report revealed that Miralax, ordered 10/7/14, had special instructions to "dissolve in 8 ounces water daily for constipation." 2. On 11/18/15 at 3:10 p.m., LN #16 was observed pouring 2 Tylenol (acetaminophen) 325 mg (milligram) tablets for Resident #20. The LN said the resident had complained of a headache and the Tylenol was PRN, or as needed. The LN crushed the tablets, mixed them in apple sauce then administered them to the resident by mouth. The resident's Physician Order Report revealed the acetaminophen order, dated 9/28/15, instructed the medication was to be given by gastric tube (g-tube), not by mouth. On 11/19/15 at 9:20 a.m., Unit Manager (UM) #1 was asked about the route of the resident's PRN acetaminophen. The UM reviewed the order then left the Nurses' Station. The UM returned to the Nursing Station at 9:25 a.m. and said the resident	F 332	procedures, including specifically on following physician's orders accurately. The monitoring of medication administration records to assure compliance with physician orders and medication administration procedures will be completed by unit managers weekly x 4, and monthly x 3 and reported to DON or designee. The audit findings will be reported to QA committee monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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	Continued From page 14 had requested her medications by mouth after her diet was upgraded by the Speech Therapist on 11/18/15. The UM said, "Now I need to match the order with that." The UM then called the physician's office to request a change in the route of administration for the resident's medications.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure there were no significant medication errors for 1 of 13 residents (#22) during medication pass observations. The failure created the potential for more than minimal harm if a decrease in the resident's pain and discomfort was delayed because an intravenous (IV) antiviral medication was not administered at the correct dose. Findings included: On 11/17/15 at 2:20 p.m., LN #3 was observed preparing Acyclovir 675 mg (milligrams) for Resident #22. The Acyclovir pharmacy label instructed, "Add 13.5 ml [milliliters] (675 mg) to NS [normal saline] 100 ml bag & infuse 113.5 mg (675 mg) intravenously over 60 minutes every 8 hours." The LN added 13.5 ml of the Acyclovir to the 100 ml bag of NS. At 2:30 pm, the LN set-up the 113.5 ml bag of Acyclovir in the IV pump, set the pump to run at 100 ml over 60 minutes, started the infusion, then	F 333	F333-- The deficient practice of not keeping residents free of significant med errors has the potential to affect 51 residents. Resident #22 IV flow rate was immediately corrected at time of discovery. The nursing staff will be in-serviced by 12/31/2015 on correct medication procedures, including specifically on following physician's orders accurately. An IV administration flow sheet has been created and will be added to all residents on IVs beginning 12/17/2015. This flow sheet specifies IV flow rates as ordered by physician. The monitoring of MARS to assure compliance with MD orders and medication administration procedures. Will be completed by unit managers weekly x 4, and monthly x 3 and reported to DON or designee. The audit findings will be reported to QA monthly x 3.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 333	Continued From page 15 left the resident's room. At 2:35 pm, LN #3 was asked what rate she set for Resident #22's Acyclovir infusion. The LN said, "100." The LN was asked to reread the pharmacy instructions for the Acyclovir. The LN read the instructions and said "113.5 ml per hours" The LN said she would immediately change the resident's IV pump to 113.5 ml/hour.	F 333		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	F356-- The deficient practice of not posting nursing staff daily information has the potential to affect 51 residents and visitors. The daily staffing information was updated on day of discovery on 11/16/2015. The staff development nurse or designee will post daily nursing staff information each day in an area where residents and visitors may review the posting. The administrator or designee will monitor weekly x 1 month and monthly x 3 months to assure compliance. The results of monitoring will be reported monthly x 3 months to QA committee.	11/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 356	Continued From page 16 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to display the nurse staffing posting in a prominent place readily accessible to residents and visitors. This affected 12 of 12 (#s 1-12) sampled residents and had the potential to affect all residents who resided in the facility and any visitors who came to the facility. Findings included: On 11/16/15 at 10:30 AM, the nurse staffing information was not found in the facility. On 11/16/15 at 10:32 AM, the Staff Development Nurse said she did not know the information needed to be posted and would post it as soon as possible.	F 356		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	F431-- The deficient practices of not consistently locking the med cart, having outdated biological specimen supplies, and the practice of pharmacy labels not matching the order has the potential to affect 51 residents. Resident #17 did have his nebulizer treatment orders verified, and did receive medications correctly according to his orders. The pharmacy label has been updated to the correct order.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 431	Continued From page 17 appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure 2 of 2 medication (med) carts were locked when unattended, pharmacy labels matched physician orders for 1 of 13 residents (#17) and that culture swabs were not outdated. The failure created the potential for a negative effect if independently mobile residents ingested medications from the unsecured med carts, or inaccurate cultures resulted from outdated swabs. Resident #17 had the potential for adverse effects when he received unnecessary albuterol breathing treatments and unreliable culture results were possible for as many as five residents. Findings included:	F 431	Nursing staff will be educated by 12/31/2015 on following correct facility procedures. This education will include specific training on double checking medication labels and comparing them to actual MD orders; and medication rights of administration; locking med carts at all times when away from cart; and always checking expiration dates on medications and biological supplies. All medication carts will be monitored to assure consistent locking by the unit manager at least weekly x 4 and monthly x 3, and findings reported to DON or designee. The monitoring results will be reported to QA committee monthly x 3. Medication room supplies will be monitored by the treatment nurse monthly and expired biologicals and medications removed. The DON or designee will assure compliance of med room monitoring monthly, and results reported to QA monthly x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 431	Continued From page 18 1. Two medication carts were observed to be unlocked and unattended as follows: a) On 11/19/15, from 9:33 am to 9:36 a.m., the D hall med cart was observed unlocked and unattended. The med cart was located in the hallway next to the west door to the D hall dining room, where an activity was being conducted with several residents present. CNA #17, who was working at a kiosk on the wall between the two doors to the D hall dining room, did not notice when the top right drawer of the med cart was opened. At 9:36 a.m., LN #10 arrived at the med cart where the top right drawer was still unlocked. The LN said she had been called away to do a bladder scan and did not realize she had left the med cart unlocked. At 9:38 a.m., CNA #17, was still at the kiosk and, when asked if she noticed the med cart drawer was open and the facility nurse was not present, stated, "No, I didn't pay attention." b) On 11/20/15 at 9:28 a.m. LN #3 and the DNS were observed as they walked away from the C hall med cart, which was unlocked. The med cart was located next the the C hall nurses' station. LN #3 went into the chart room on the opposite side of the nurses' station from the med cart and the DNS walked toward D hall. Surveyors observed the unlocked and unattended med cart until 9:35 a.m. During that time, LN #3 remained in the chart room and a COTA (Certified Occupational Therapy Assistant) brought a resident to the sitting area just feet from the unlocked med cart then, where the resident was	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 431	Continued From page 19 left alone. At 9:35 am, the DNS returned to the area. LN #3 arrived moments later and said she "must have" left the med cart unlocked. 2. On 11/17/15 at 9:35 a.m., LN #2 was observed as she prepared then administered an albuterol nebulizer treatment for Resident #17. The LN said it was a PRN treatment. The pharmacy label on the medication read, "Inhale one vial by mouth via nebulizer three times daily." The November 2015 Physician Order Report documented the albuterol nebulizer treatment was ordered "3 times daily as needed" on 9/7/15. On 11/17/15 at 10:05 a.m., LN #2 was asked about the discrepancy between the pharmacy label instructions for three times daily and the order three times daily PRN. The LN said there had been "lots" of medication changes and the resident's hospice provider "won't change the label." 3. On 11/20/15 at 9:45 AM, the D Hallway Medication Room was observed with the Staff Development Nurse (SDN). A drawer in the room had five biological culture swab kits with an expiration date of April 2015. The SDN said the culture kits were expired and took them out of the room.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F441-- The deficient practice of staff failing to correctly wash hands has the potential to affect 51 residents.	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 441	Continued From page 20 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure staff	F 441	All nursing staff will be educated by 12/31/2015, including education on hand washing. The infection control nurse will monitor all staff compliance with hand washing at least weekly x 4 and monthly x 3 and report findings to DON or designee. The results of monitoring will be reported monthly x 3 months to QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 441	Continued From page 21 followed accepted infection control practice when washing their hands. This was true for1 of 6 Licensed Nurses (#10) during medication pass observations for 1 of 13 residents (#23). Failure to perform proper hand washing technique created the potential for infections from cross contamination. Findings included: On 11/19/15 at 11:55 a.m., LN #10 was observed as she checked Resident #23's blood glucose, washed her hands, turned off the water faucet with her bare hand, then dried her hands and left the resident's room. The LN returned to the resident's room at 12:07 p.m., turned on the water faucet with her bare hand, washed her hands, turned off the water faucet bare handed then dried her hands. The LN then drew up a scheduled dose of insulin which she administered to the resident at 12:10 p.m. The LN then repeated the same technique to wash her hands and then left the resident's room. On 11/19/15 at 12:25 p.m., LN #10 did not respond when informed of the observations and asked about the hand washing technique.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	F514-- The deficient practice of resident records not being complete, accurate, and/or accessible has the potential to affect 51 residents. Resident #3's physician orders were verified, and the current orders are being followed correctly for use of drinking straw. As of 11/19/2015, the speech therapist evaluated current orders for resident #3 and agreed that current orders	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 514	Continued From page 22 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain complete and accurate clinical records for residents in the facility. This was true for 2 of 14 (#s 1 & 3) sampled residents and one (#18) random resident with incomplete documentation as evidenced by: * Physician orders were not discontinued when Resident #3's treatment changed, * Physician visit notes were not in Resident #1's medical record, and, * Transfer orders were not accurately transcribed to Resident #18's facility orders and MAR. This deficient practice increased the risk for care decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included: 1. Resident #3 was readmitted to the facility on 7/16/13 with multiple diagnoses, including a history of cerebrovascular accident with dysphagia (stroke with difficulty swallowing). The resident's November 2015 Physician Order Report documented a 1/6/15 order for, "Free Water protocol to improve fluid intake. No Straws..." The resident's Speech Therapy notes documented:	F 514	are correct for resident's status. Physician orders were updated by medical records. The physician visit notes for Resident #1 for October 13, 2015 were received on 11/19/2015 and placed in chart. Resident #18's nebulizer medication was verified as to current order, and the label on the medication card has been corrected to reflect present physician order to PRN. The medication administration record was updated to reflect current orders. This resident was a recent readmit after hospitalization with a change in nebulizer order from scheduled to PRN. Licensed nurses will be educated by 12/31/2015 on correct procedure for verification of physician's orders, MARS, and pharmacy labels for correctness. (See policy/procedure on physician orders) A policy and procedure for recap orders and MARS will be developed and implemented by 12/31/2015. Nurses and medical records will be educated on the procedure by 12/31/2015. The medical records director will audit resident charts to assure physician notes are in the chart within 7 days from date of physician visit. These audits will occur weekly. The medical records director will report the audits to QA committee monthly x 3. Medical records and nursing supervisor will audit weekly x 4 and monthly x 3 for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 514	Continued From page 23 *1/6/15: "Staff reports significantly reduced fluid intake with thickened liquids...P[atien]t trialed on thin liquids with mild overt s/s [signs and symptoms] of aspiration, throat clearing, and mild vocal changes. Pt placed on Frazier Free water protocol and staff educated on the protocol, thin water at bedside with no straws..." and *1/16/15: "Patient was seen for final visit ... Patient was able to tolerate straw ... Patient's intake of liquids has markedly increased since upgraded to thin." The resident's 1/12/15 Physician Telephone Orders documented, "Upgrade liquids to thin consistency..." The resident's current tray card did not document the resident was on a Free Water protocol without straws. The resident was observed drinking thin liquids via straws in cups without any swallowing issues during a lunch observation on 11/17/15 and a breakfast on 11/18/15. On 11/19/15 at 11:00 AM, Speech Therapist (ST) #15 said the resident had been safe with straws since January 2015. She reviewed the resident's ST notes and said the Free Water Protocol and no straw order should have been discontinued on 1/16/15, when another ST determined the resident was safe with straws. 2. Resident #1 was admitted to the facility on 9/24/15 with multiple diagnoses, including generalized muscle weakness and hypertension.	F 514	compliance of recaps and MARS procedure. The results will be reported by DON or designee to QA monthly x 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 514	Continued From page 24 On 11/16/15 at 2:45 p.m., the resident's medical record was reviewed; a record of physician visits for October 2015 was not found in the resident's medical record. On 11/17/15 at 2:00 p.m., LN #12 said the resident's physician's notes for October 2015 could still be on their folder file and had not yet been placed in Resident #1's medical record. On 11/19/15 at 10:35 a.m., the Business Office Manager handed Resident #1's Physician's October notes with date of service 10/13/15. On the top of the paper was the faxed time and date: 09:17 [9:17 a.m.], 11/19/15. 3. On 11/17/15 at 9:55 a.m., LN #2 was observed as she set-up and turned on an albuterol-ipratropium (DuoNeb) nebulizer treatment for Resident #18 then left the room. The LN said the treatment was scheduled. The pharmacy label on the DuoNeb medication read, "Inhale...via nebulizer 4 times daily." The resident's November 2015 Physician Order Report documented that on 11/6/15 the DuoNeb treatments were ordered "every 6 hours as needed [PRN] for COPD [chronic obstructive pulmonary disease]." Patient Discharge Instructions from a local hospital, also dated 11/6/15, included an order for the DuoNeb treatment every 6 hours (scheduled). The discharge instructions did not contain an order to give the DuoNeb treatment as needed. On 11/19/15 at 10:45 am, LN #10 was asked if Resident #18's DuoNeb treatments were PRN or scheduled. The LN stated, "It's scheduled." The	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KARCHER ESTATES, LLC	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 514	Continued From page 25 LN and surveyor reviewed the resident's November 2015 MAR and noted that both PRN and scheduled DuoNeb treatments were listed. When asked if it was possible the resident could receive as many as 8 DuoNeb treatments per day, the LN said "Yes." Upon request, the LN looked in the medication cart for a box of DuoNeb labeled PRN for the resident. The LN found one box of DuoNeb which she said was the resident's scheduled DuoNeb. The resident's November 2015 MAR contained documentation that scheduled DuoNeb treatments were administered 4 times daily from 11/7 through 11/17/15 and 3 times on 11/18/15, and PRN DuoNeb treatments were administered on 11/8, 11/10 and 11/18/15. The documentation revealed that the resident received 5 DuoNeb treatments on 11/8 and 11/10/15. On 11/19/15 at 11:05 a.m., Unit Manager (UM) #1 and the Nurse Consultant (NC) were asked about the DuoNeb orders. The UM and NC reviewed the DuoNeb orders in the Patient Discharge Instructions and Physician Order Report. The NC said the order for scheduled DuoNeb was incorrectly transcribed as PRN on the Physician Order Report, and that the MAR should have contained only the scheduled DuoNeb order. The NC instructed the UM to clarify the order with the resident's physician.	F 514		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

December 8, 2015

Benjamin Roedel, Administrator
Karcher Estates, LLC
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr.. Roedel:

On **November 16, 2015**, an unannounced on-site complaint survey was conducted at Karcher Estates, LLC. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006835

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from November 16 to November 20, 2015.

The following observations were completed:
The entire kitchen was observed;
Food temperatures and expiration dates were observed;
Food preparation and service was observed;
The walk-in cooler temperature was observed;
A test tray was observed for temperature and palatability;
Dietary staff was observed working in the kitchen; and,
A resident with pureed food orders was observed for two meals.

The following documents were reviewed:
A resident's pureed food orders;
Food and equipment temperature logs;
Resident Council minutes from August to October 2015;

The facility's Grievance file from January to November 2015; and,
The Dietary Manager's credentials.

The following interviews were completed:
Four residents and two family members were interviewed about food concerns;
Residents in the group interview were asked about food concerns;
Four dietary staff members were interviewed; and,
The Certified Dietary Manager (CDM) was interviewed.

ALLEGATION #1: The complainant stated the food was cold and food temperatures were not taken regularly, including the milk.

FINDINGS #1: Food tray line temperatures and a sample test tray was observed to be within an acceptable range, including milk.

Food temperature logs were reviewed and food temperatures were within an acceptable range, including milk. The grievance file did not document food temperatures was an issue. The Resident Council minutes did not document food temperatures was a concern.

Four individual residents, two family members, and four residents in the group interview said the food temperatures were not a concern. Three dietary staff and the CDM were interviewed and they said food temperatures were taken every day for each meal.

Based on observation, record review, resident, family, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #1: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2: Kitchen staff thaw out frozen vegetables on the grill. The walk-in fridge temperature is 41.5 degrees, which is higher than requirements allow. Food in the walk-in fridge and syrup in the dry storage area is expired. The Certified Dietary Manager and dietary staff are not knowledgeable about food code requirements.

FINDINGS #2: Food preparation was observed and frozen carrots were observed to be taken from the freezer and emptied into a pan to be put in the facility's steamer. The walk-in fridge was observed to be 34 degrees and within the requirements. Food in the walk-in fridge and dry storage, including the syrup were observed to have expiration dates in the future. Dietary staff were observed to prepare and serve food within the food code requirements.

The walk-in refrigerator temperature logs were reviewed and were within acceptable parameters. The Certified Dietary Manager's credentials were reviewed and they met the food code requirements.

Four dietary staff and the Certified Dietary Manager were asked various food code questions regarding kitchen sanitation, food preparation and food service and no concerns were found. The Certified Dietary Manager said vegetables were taken from the freezer and then placed in the steamer to maintain their nutrients. The Certified Dietary Manager said food is rotated, labeled and dated to ensure expiration dates do not become a problem. The Certified Dietary Manager said she has been a certified dietary manager since 1999.

Based on observations, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #2: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3: The pureed food is not pureed enough.

FINDINGS #3: Pureed food was observed during the tray line observation and the food was of pureed consistency. A resident with a puree diet was observed for two meals and the resident did not have difficulty eating the pureed food.

The grievance file did not document puree food consistency was an issue.

The Certified Dietary Manager said staff received training on pureed food preparation and the Certified Dietary Manager and dietary cooks conduct spot checks to ensure the food is of the correct consistency.

Based on observations, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION #3: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

D. Scott

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

March 8, 2016

Benjamin Roedel, Administrator
Karcher Estates, Llc
1127 Caldwell Boulevard,
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr.. Roedel:

On **November 20, 2015**, an unannounced on-site complaint survey was conducted at Karcher Estates, Llc. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006900

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from November 16, 2015 to November 20, 2015.

Eight residents were observed for signs of over-sedation, two residents with peripherally inserted central catheter (PICC) lines were observed for proper care and treatment, and twenty-five medication administrations were observed.

The clinical records of two identified residents and seven other residents were reviewed for quality of care and medication concerns, and the clinical records of two other residents were reviewed for PICC line care and management. In addition, the facility's grievance files, Incident and Accident reports, and investigations of Allegations of Abuse, all for January to November 2015, were reviewed as were Resident Council meeting minutes for August to October 2015.

Four individual residents, Resident Group, and two family members, were interviewed regarding quality of care, including medications and pain management. Several licensed nurses, the Director of Nursing Services, and a hospice nurse were interviewed regarding various quality of care issues, including medications, pain management, and PICC line care and management.

Allegation #1: An identified resident died within an hour after a hospice nurse doubled the strength of a fentanyl patch, administered Haldol, Ativan, and Benadryl simultaneously by intramuscular injection, then left the facility without notifying the staff on duty.

Findings #1: Review of the identified resident's clinical record and interviews with the licensed nurses and hospice nurse, revealed the resident was actively dying when he/she was admitted to the facility. Shortly after admission, the resident began to experience agitation related to end of life. The hospice nurse, who was still present since the resident's admission, increased the fentanyl patch then administered separate injections of Haldol, Ativan, and Benadryl per physician order. Nursing notes documented the hospice nurse remained in the facility for nearly four hours after the medications were administered, communicated with the facility nurse before leaving the facility, and returned to the facility an hour later when summoned.

The allegation was not substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: An identified resident's PICC line was left open and did not contain a port seal or clamp.

Findings #2: The identified resident was no longer residing in the facility when the complaint was investigated.

The clinical records of the identified resident and two other residents with a PICC line were reviewed and no issues regarding PICC line care and management were identified. Two residents with a PICC line were observed and interviewed. The residents did not express any concerns about the PICC line care and management. In addition, the PICC line clamp and cap were observed in place prior to a medication administration for one of those residents. The Director of Nursing Services said the nurses were trained to ensure the PICC line cap is on and the line clamped, except when flushing the line or administering medication.

Based on the observation, record review, resident and staff interviews, the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt