



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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 208-364-1888

July 7, 2017

Nathan Chinchurreta, Administrator  
Karcher Post-Acute & Rehabilitation Center  
1127 Caldwell Boulevard  
Nampa, ID 83651-1701

Provider #: 135110

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Mr. Chinchurreta:

On **June 27, 2017**, a Facility Fire Safety and Construction survey was conducted at **Karcher Post-Acute & Rehabilitation Center** by the Department of Health & Welfare, 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 Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency 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. Please provide **ONLY ONE**

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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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 20, 2017**. Failure to submit an acceptable PoC by **July 20, 2017**, may result in the imposition of civil monetary penalties by **August 9, 2017**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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 **August 1, 2017**, (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 **August 1, 2017**. A change in the seriousness of the deficiencies on **August 1, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 1, 2017**, includes the following:

Denial of payment for new admissions effective **September 27, 2017**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **December 27, 2017**, 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.**

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 **June 27, 2017**, 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:

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<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 **July 20, 2017**. If your request for informal dispute resolution is received after **July 20, 2017**, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

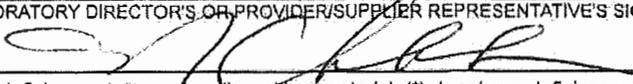
Printed: 07/06/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>KARCHER POST-ACUTE &amp; REHABILITATION (</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>
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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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  The facility is a single story type V(111) structure with a two hour wall between the common area shared with the adjacent independent living facility. The building was originally constructed in 1989, with a two-hour rated wall and fire door assembly added in 2014. The facility is fully protected by an automatic fire alarm and sprinkler system. Currently the facility is licensed for 66 SNF/NF beds.  The following deficiencies were cited during the annual Fire/Life Safety survey conducted on June 27, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Health Care Occupancies, in accordance with 42 CFR 483.470.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire, Safety and Construction	K 000	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Karcher Post-Acute and Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”	
K 211 SS=F	NFPA 101 Means of Egress - General  Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that rated assemblies were inspected in accordance with NFPA 80 and/or NFPA 105, as applicable. Failure to inspect and test rated assemblies has the potential to hinder system performance as	K 211	<b>K211</b>  All fire doors have been inspected and documentation completed. All fire doors were in proper working condition.  Door inspections will be put into TELS program through direct supply for documentation purposes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>7/19/17</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 211	<p>Continued From page 1</p> <p>designed. This deficient practice affected 55 residents, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 55 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of provided facility annual inspection records conducted on June 27, 2017 from approximately 9:00 AM to 10:00 AM, no records were available demonstrating an initial or annual inspection and testing of rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of this requirement.</p> <p>2) During the facility tour conducted on June 15, 2017 from approximately 10:00 AM to 3:30 PM, observation of installed doors revealed doors in 5 of 5 smoke compartments were labeled as smoke or fire resistive, and ranged in fire/smoke protective ratings from 20 minutes to 90 minutes.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8:</p>	K 211	<p>The Maintenance Director will track and trend audit findings and report results to the QAPI committee, to identify opportunities for performance improvement monthly x 3 months and annually thereafter.</p> <p>Maintenance Director or Designee will monitor compliance.</p> <p>Date Certain 7/19/2017</p>	

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K 211	Continued From page 2 (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6  7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.  NFPA 80 5.2* Inspections. 5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.  NFPA 105 5.2 Specific Requirements. 5.2.1* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.	K 211		
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)  Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32	K 325		

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K 325	<p>Continued From page 3</p> <p>gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols</p> <ul style="list-style-type: none"> <li>* Dispensers shall have a minimum of 4-foot horizontal spacing</li> <li>* Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room</li> <li>* Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30</li> <li>* Dispensers are not installed within 1 inch of an ignition source</li> <li>* Dispensers over carpeted floors are in sprinklered smoke compartments</li> <li>* ABHR does not exceed 95 percent alcohol</li> <li>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</li> <li>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</li> </ul> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation and condition of ABHR dispensers has the potential to inadvertently spill flammable liquids, increasing the risk of fires. This deficient practice affected 55 residents, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF residents and had a census of 55 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility inspection records conducted on June 27, 2017 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR</p>	K 325	<p><b>K325</b></p> <p>All Alcohol-Based Hand-Rub Dispensers have been inspected and documentation completed. All Dispensers were in proper working condition.</p> <p>Alcohol-Based Hand-Rub Dispensers will be inspected and documented for proper working condition upon replacement</p> <p>The Maintenance Director will refer any continued negative findings to the QAPI committee, to identify opportunities for performance improvement monthly.</p> <p>Maintenance Director or Designee will monitor compliance.</p> <p>Date Certain 7/19/2017</p>	

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K 325	<p>Continued From page 4</p> <p>dispensers was performed when refilling dispensers.</p> <p>2) During the facility tour conducted on June 27, 2017 from approximately 10:00 AM to 3:30 PM, observation of installed ABHR dispensers revealed manually activated ABHR dispensers were installed in five of five smoke compartments. When asked if the facility tested dispenser operation at the time a refill was installed, the Maintenance Supervisor stated he was not aware of the requirement for dispenser testing.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p>	K 325		

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K 325	Continued From page 5 (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free	K 325		

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K 325	Continued From page 6 activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device. (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325		
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie  Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This Standard is not met as evidenced by: Based on observation, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations in smoke barriers could allow fire, smoke and dangerous gases to pass between	K 372	<b>K372</b>  The unsealed two (2) inch conduit, passing from central supply to the corridor by room 582, has been fire sealed.  Audits will be conducted by Maintenance Director Annually for any further potential need for fire sealant.  The Maintenance Director will track and trend audit findings and report results to the QAPI committee, to identify opportunities for performance improvement monthly.  Maintenance Director or Designee will monitor compliance.  Date Certain 7/19/2017	

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NAME OF PROVIDER OR SUPPLIER <b>KARCHER POST-ACUTE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
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K 372	<p>Continued From page 7</p> <p>compartments during a fire. This deficient practice affected 4 residents in 1 of 5 smoke compartments, staff and visitors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 55 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 27, 2017 from approximately 11:00 AM to 3:00 PM, an above the ceiling inspection at the 2-hour wall adjacent to room 582, revealed an unsealed two (2) inch conduit passing from central supply into the corridor.</p> <p>Actual NFPA standard:</p> <p>8.5.6 Penetrations. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met.</p> <p>8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through</p>	K 372			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2017</b>
NAME OF PROVIDER OR SUPPLIER <b>KARCHER POST-ACUTE &amp; REHABILITATION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
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K 372	Continued From page 8 Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m <sup>2</sup> ) between the exposed and the unexposed surface of the test assembly.	K 372		
K 918 SS=D	NFPA 101 Electrical Systems - Essential Electric System  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918	<b>K918</b>  The battery for the emergency light in the generator room has been replaced and observed to be in good working condition.  The Maintenance Director will audit monthly for proper working condition.  The Maintenance Director will track and trend audit findings and report results to the QAPI committee, to identify opportunities for performance improvement monthly.  Maintenance Director or Designee will monitor compliance.  Date Certain 7/19/2017	

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

Printed: 07/06/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/27/2017</b>
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K 918	<p>Continued From page 9 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure the Emergency Power Supply System (EPSS) was provided with emergency lighting in accordance with NFPA 110. Failure to provide emergency lighting in locations where the prime mover is in the same space as the transfer switch, has the potential to hinder repair operations in the event of a generator failure. This deficient practice affected staff and vendors on the date of the survey. The facility is licensed for 66 SNF/NF beds and had a census of 55 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on June 27, 2017 from approximately 1:00 PM to 3:30 PM, observation and operational testing of the emergency light located in the generator room revealed the battery on the light was dead.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>7.3 Lighting. 7.3.1 The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access.</p>	K 918		