



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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October 3, 2017

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

Provider #: 135110

Dear Mr. Chinchurreta:

On **September 20, 2017**, a survey was conducted at Karcher Post-Acute & Rehabilitation Center 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 an isolated deficiency that constitutes actual 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.) **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.

Nathan Chinchurreta, Administrator
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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 **October 13, 2017**. Failure to submit an acceptable PoC by **October 13, 2017**, may result in the imposition of civil monetary penalties by **November 5, 2017**.

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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

Civil money penalty,

Denial of payment for new admissions effective December 20, 2017

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 20, 2018**, 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.

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 **October 13, 2017**. If your request for informal dispute resolution is received after **October 13, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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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,

A handwritten signature in black ink that reads "Nina Sanderson for". The signature is written in a cursive style with a large initial "N" and a long, sweeping underline.

Nina Sanderson, LSW, Supervisor
Long Term Care

ls/lj
Enclosures

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

PRINTED: 12/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/20/2017
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint investigation survey conducted at the facility September 18, 2017 to September 20, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN , Team Coordinator Debra Parker, RN Jackie Copas, RN Jacqueline Miles, RN</p> <p>Abbreviations:</p> <p>DNS = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MD = physician mg = milligram NN = Nurse's Notes RN = Registered Nurse</p>	F 000			
F 157 SS=D	<p>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14)</p> <p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p>	F 157		10/18/17	

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

TITLE

(X6) DATE

Electronically Signed

10/11/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and</p>	F 157	This Plan of Correction is prepared and		

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F 157	<p>Continued From page 2</p> <p>policy review, it was determined the facility failed to notify a physician timely of a significant medication error. This was true for 1 of 8 residents (#1) sampled for medication administration. The deficient practice created the potential for harm when a physician did not have updated information on the resident's condition after she received an extra dose of a muscle relaxant. Findings include:</p> <p>The facility's Medication Error policy and procedure, revised June 2016, documented if a medication error was made, the resident's physician should be notified, and the facility should place the resident on "alert" (increased monitoring).</p> <p>Resident #1 was admitted to the facility on 8/16/17 with diagnoses which included multiple sclerosis and malignant neoplasm (abnormal mass) in the lower lung, and muscle weakness. The resident was receiving hospice services at home, and had been admitted for a 5 day hospice respite stay.</p> <p>Resident #1's 8/16/17 admission physician's orders included Baclofen (a muscle relaxant) 40 milligrams (mg) every day at bedtime, and 20 mg every morning.</p> <p>Resident #1's Medication Administration Record (MAR) documented the resident received a 40 mg dose of Baclofen as ordered on 8/16/17 at 10:30 pm.</p> <p>Resident #1's Nurse's Notes (NN) dated 8/17/17, documented Resident #1 was given a second 40 mg dose of Baclofen at 2:00 am, and the dose</p>	F 157	<p>submitted as required by law. By submitting this Plan of Correction, Karcher Post-Acute Care & Rehabilitation Center 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.</p> <p>F-157</p> <p>Resident # 1 no longer resides in the facility. Resident was originally sent to emergency room for evaluation and treatment and remained in hospital over night for observation and discharged home per resident request.</p> <p>Current Residents progress notes have been reviewed for the past 30 days for medication/treatment orders, changes in condition and behaviors, for responsible party notification of changes. Corrections made when needed.</p> <p>Licensed Nurses (LN□s), Resident Care Managers (RCM□s), MDS nurse have be re-educated on proper Physician and Family/Resident notification process. Nurses involved in the incident have been disciplined for failure to follow nursing standards of practice.</p>		

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F 157	<p>Continued From page 3</p> <p>was a "medication error." The note did not document the physician was notified of this error.</p> <p>On 8/17/17 at 7:58 am, Resident #1's NN documented, "MD [physician] and husband notified regarding extra dose of Baclofen given. Will continue to monitor." There was no documentation in the resident's clinical record regarding physician acknowledgement or response to the notification.</p> <p>On 9/19/17 at 10:45 am, the Director of Nursing Services (DNS) stated she was not sure, from reading the NN, how Resident #1's physician was notified of the error. The DNS stated Resident #1's physician was the hospice medical director, and she had contacted the hospice agency to see if there was a record that the physician had been notified of the error, but the hospice agency had no such record. The DNS stated she would expect the physician to be notified as soon as the medication error had been discovered, and the physician's response should be documented in the resident's clinical record.</p> <p>On 9/20/17 at 1:00 pm, Registered Nurse (RN) #1 stated she realized she had made a the medication error for Resident #1 at 4:00 am on 8/17/17, called the hospice physician and left a message on the answering machine. RN #1 stated she thought it was earlier than the 7:58 am notification documented in the NN, but as it had been a "busy shift" she could not be certain. RN #1 stated she did not receive confirmation the physician received the message or was aware of the medication error.</p>	F 157	<p>During the morning Managing Acute Condition Change (MACC) meeting, the DNS, RCMs and MDS nurse will review resident interdisciplinary progress notes to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified. This process is to ensure other residents are not adversely affected.</p> <p>The RCMs will complete a weekly audit x 8 weeks of residents reviewed during MACC meeting to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified. Audits will be forwarded to the DNS and Administrator for review and follow up, if needed.</p> <p>Audit findings and reports results will be reviewed by the QAPI committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>The DNS and Administrator will ensure compliance.</p> <p>Compliance date: 10/18/2017</p>		
F 281	SERVICES PROVIDED MEET PROFESSIONAL	F 281		10/18/17	

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F 281 SS=G	Continued From page 4 STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow professional nursing standards regarding medication administration, and failed to respond appropriately to a medication error. This was true for 1 of 8 residents (#1) sampled for nursing standards. Resident #1 was harmed when the facility administered an extra dose of the muscle relaxant Baclofen, resulting in the resident receiving more than the recommended total daily dose in a 12 hour period. The resident required hospitalization for respiratory depression, a known symptom of Baclofen overdose. Findings include: The American Nurses Association, (2015), "Nursing: Scope and Standards of Practice, 3rd Edition" pp.4-5 Silver Spring, MD: ANA, The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. "Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse ' s decision-making...Assessment...the registered nurse collects pertinent data and information	F 281	F-281 Resident # 1 no longer resides in the facility. Resident was originally sent to emergency room for evaluation and treatment and remained in hospital over night for observation and discharged home per resident request. Current Residents progress notes have been reviewed for the past 30 days for proper documentation of the nursing process with appropriate assessment and interventions. Corrections made when needed. RN#1 is no longer employed at the facility for failing to adhere to standards of conduct and nursing standards of practice.. Licensed Nurses (LN□s), Resident Care Managers (RCM□s), MDS nurse have been re-educated on proper Medication Management and Administration and Nursing Scope and Standards of Professional Practice.		

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F 281	<p>Continued From page 5 relative to the consumer's health or the situation....Implementation...the registered nurse implements the identified plan."</p> <p>The facility's Medication Error policy and procedure, revised June 2016, documented if a medication error was made, the resident's physician should be notified, and the facility should place the resident on "alert" (increased monitoring).</p> <p>The 2018 Nursing Drug Handbook documented for Baclofen: *The maximum daily dosage of the oral form of the medication should not exceed 80 milligrams (mg). *The time for the medication to take effect and the duration of effectiveness was unknown, with peak effectiveness at 2-3 hours, and half-life of 2 1/2 to 4 hours. *Adverse reactions included difficulty breathing. *Signs and symptoms of overdose included drowsiness and "respiratory depression."</p> <p>Resident #1 was admitted to the facility on 8/16/17 for a five day hospice respite stay, with diagnoses including multiple sclerosis, muscle weakness, and a malignant tumor in her lung.</p> <p>Resident #1's 8/16/17 physician's admission orders documented the resident received scheduled doses of Baclofen in the morning (20 mg) and at bedtime (40 mg), for a total of 60 mg daily. No other Baclofen doses were ordered.</p> <p>Resident #1's Medication Administration Record (MAR) for 8/16/17 documented the resident received 40 mg of Baclofen at 10:30 pm, as</p>	F 281	<p>During the morning Managing Acute Condition Change (MACC) meeting, the DNS, RCMs and MDS nurse will review resident interdisciplinary progress notes to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified. This process is to ensure other residents are not adversely affected.</p> <p>The DNS/RCMs will complete a weekly audit x 8 weeks of Licensed Nurses Medication Administration process.</p> <p>The DNS will track and trend audit findings and report results to the QAPI committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>The DNS and Administrator will ensure compliance.</p> <p>Compliance date: 10/18/17</p>		

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F 281	<p>Continued From page 6 ordered by the physician.</p> <p>Resident #1's Nurse's Notes (NN) dated 8/17/17, documented Resident #1 was given a second 40 mg dose of Baclofen at 2:00 am, and the dose was a "medication error." The NN did not document an assessment of Resident #1's condition, or that the resident's physician was notified of the error, for the next 6 hours.</p> <p>On 8/17/17, no time documented, the facility initiated a medication error report, which documented the 2:00 am administration of the Baclofen was a "medication error."</p> <p>On 8/17/17 at 7:58 am, Resident #1's Nurse's Notes (NN) documented the resident's physician was notified of the medication error, but no acknowledgement or response was documented.</p> <p>On 8/17/17 at 8:00 am, Resident #1's Vital Signs Log documented a blood pressure of 138/70, temperature as 98.4 degrees, pulse 70, respirations 18, and oxygen saturations of 97% on room air. Resident #1's clinical record did not document any further assessments or progress notes until 12:00 noon.</p> <p>Resident #1's MAR documented her morning dose of 20 mg of Baclofen was administered between 6:30 am and 10:00 am (no more specific administration time available). The resident had received a total of 100 mg of Baclofen (20 mg more than the maximum allowable daily dose, and 40 mg more than she normally received daily) in less than 12 hours.</p> <p>On 8/17/17 at 12:00 noon, Resident #1's NN</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>documented the resident was "awake but sleepy."</p> <p>On 8/17/17 at 1:36 pm, Resident #1's NN documented a decline in her level of consciousness and hospice was called.</p> <p>On 8/17/17 at 2:05 pm, Resident #1's NN documented the resident was responsive only to painful stimuli, and per hospice direction 911 was called and the resident taken to the hospital.</p> <p>On 8/17/17, Resident #1's hospice "Transfer Summary" documented Resident #1 was taken to the hospital after becoming unresponsive, and admitted for respiratory depression and a urinary tract infection.</p> <p>On 9/19/17 at 10:45 am, the Director of Nursing Services (DNS) stated Resident #1 had been in the facility less than 24 hours when the medication error occurred. The DNS stated the facility had a scheduled computer update, causing the main system to be down, which took place on the night shift between 8/16/17 and 8/17/17. The DNS stated it was during this time the medication error occurred. The DNS stated the facility had a back up system to accurately track medication administration during the computer down time, but for some reason RN #1 had not utilized that system. The DNS stated it was her understanding that Resident #1 requested her bedtime dose of Baclofen in the middle of the night, and since the resident was new and on hospice, RN #1 administered the medication to the resident without first checking that a dose was scheduled. The DNS stated, "[RN #1] failed to actually look at the back up</p>	F 281			

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F 281	<p>Continued From page 8 computer to ensure the medication had not been given [at bedtime]."</p> <p>On 9/20/17 at 1:00 pm, RN #1 stated she first recognized the medication error on 8/17/17 when the computers "came back up" at approximately 4:00 am. RN #1 stated she thought she called the physician and left a message on his answering machine regarding the error, but did not get a response. After reviewing the documentation that the physician had actually been notified at 7:58 am, almost 4 hours after she recognized the error, RN #1 stated he had been busy with other tasks and did not realize so much time had passed. RN #1 stated she took Resident #1's vital signs at the time she realized the medication error, but did not document them. RN #1 stated she had done no further assessments of the resident prior to the end of her shift, and had not given the oncoming nurse "details" of the medication error at shift change (approximately 6:00 am). RN #1 stated she had given the 2:00 am dose of Baclofen because the resident stated she did not get her bedtime dose.</p> <p>Resident #1 was harmed when the facility administered an extra dose of Baclofen, which was not ordered by the physician, then failed to notify the physician or monitor the resident's reaction to the additional medication. The resident later became sleepy, then unresponsive. The resident transported emergently to the hospital, where she was admitted for respiratory depression, a known symptom of Baclofen overdose.</p>	F 281			