



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

January 19, 2018

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

Provider #: 135110

Dear Mr. Chinchurreta:

On **January 19, 2018**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **December 18, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F156 -- S/S E -- CFR 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) Notice of Rights, Rules, Services Charges**
- **F208--S/S D--CFR483.10(c)(2)(i-ii,iv,v)(3), 483.21(b)(2) Right to Participate planning Care-Revise Care Plan**

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.

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 **January 29, 2018**.

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

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

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

- The administrator must sign and date the first page of 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*.

As noted in the Bureau of Facility Standards' letter of **December 5, 2017**, following the survey of **October 18, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for a Civil Monetary Penalty, Denial of Payment for New Admissions and termination of the provider agreement on **March 20, 2018**, if substantial compliance is not achieved by that time.

On **January 17, 2018**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **February 1, 2018**
- **Termination effective March 20, 2018**

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.

Nathan Chinchurreta, Administrator
January 19, 2018
Page 3 of 3

If you believe the 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, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **January 29, 2018**. If your request for informal dispute resolution is received after **January 29, 2018**, 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,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj

Nathan Chinchurreta, Administrator
January 19, 2018
Page 4 of 3

Enclosures

| | | | | | |
|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
| 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} | INITIAL COMMENTS The following deficiencies were cited during the on-site revisit survey conducted at the facility from January 18, 2018 and January 19, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Jenny Walker, RN Cecilia Stockdill, RN Survey Abbreviations: MDS = Minimum Data Set | {F 000} | | | |
| {F 156} SS=E | NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - | {F 156} | | 1/30/18 | |

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

TITLE

(X6) DATE

Electronically Signed

01/30/2018

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: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| 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 156} | <p>Continued From page 1</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and</p> <p>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older</p> | {F 156} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| 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 156} | Continued From page 2 Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to | {F 156} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| 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 156} | Continued From page 3 residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally | {F 156} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| 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 156} | Continued From page 4 and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those | {F 156} | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------|
| 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 156} | <p>Continued From page 5</p> <p>services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, Interested Party and staff interview, it was determined the facility failed</p> | {F 156} | <p>This Plan of Correction is prepared and submitted as required by law. By</p> | | |

| | | | | | |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
| 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 156} | <p>Continued From page 6</p> <p>to ensure a resident's Power of Attorney (POA) and/or Responsible Party (RP) had the name and contact information for the residents' physician. This was true for 5 of 5 residents (#2, and #15-18) sampled for resident rights. The deficient practice created the potential for harm when the POAs or RPs did not have sufficient information to make care decisions. Findings include:</p> <p>The facility provided several undated Medical Director Information Letters, which included Resident #s 2, and #15-18's name on them. The letters had a circle around the physician's name and contact information.</p> <p>1. Resident #2 was admitted to the facility on 3/1/16 with multiple diagnoses, including Alzheimer's disease and muscle weakness. Resident #2's face sheet documented she had designated a POA to make decisions on her behalf.</p> <p>The quarterly MDS assessment, dated 11/10/17, documented Resident #2 experienced severe cognitive impairment.</p> <p>On 1/18/18 at 3:35 PM, Resident #2's POA said the facility had never provided him/her the physician's contact information.</p> <p>2. Resident #15 was admitted to the facility on 3/22/17 with multiple diagnoses, including dementia. Resident #15's face sheet documented she had designated a POA to make decisions on her behalf.</p> <p>The quarterly MDS assessment, dated 12/29/17, documented Resident #15 experienced moderate</p> | {F 156} | <p>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-156</p> <p>Residents #2;#15;#16;#17;#18; representative □s/POA have been updated regarding MD information.</p> <p>Current residents will be given a letter with the name of their primary MD on It.</p> <p>A letter has been added to the Admission Packet outlining the contact information for the Medical Director and any other Physician □s contact information as requested by the resident.</p> <p>The Social Worker and/or the admissions coordinator have been re-educated on the use of the letter notifying a resident of their physician.</p> <p>New admission packets will be reviewed during morning IDT meeting. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify</p> | | |

| | | | | | |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
| 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 156} | <p>Continued From page 7 cognitive impairment.</p> <p>3. Resident #16 was admitted to the facility on 10/20/16 with multiple diagnoses, including a left femur fracture. Resident #16's face sheet documented she had designated a POA to make decisions on her behalf.</p> <p>The annual MDS assessment, dated 11/4/17, documented Resident #16 was cognitively intact.</p> <p>4. Resident #17 was admitted to the facility on 3/11/16 with multiple diagnoses, including Alzheimer's disease. Resident #17's face sheet documented she had designated a RP to make decisions on her behalf.</p> <p>The quarterly MDS assessment, dated 12/10/17, documented Resident #17 experienced severe cognitive impairment.</p> <p>5. Resident #18 was admitted to the facility on 2/11/17 with multiple diagnoses, including a right femur fracture. Resident #18's face sheet documented she had designated a RP to make decisions on her behalf.</p> <p>The quarterly MDS assessment, dated 11/7/17, documented Resident #18 experienced moderate cognitive impairment.</p> <p>None of the Medical Director Information Letters were found in Residents #2's, and #15-18's clinical record.</p> <p>On 1/19/18 at 7:30 AM, the Activity Director said she had been asked to call residents' POAs and RPs to inform them of how to contact the</p> | {F 156} | <p>opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 1/30/18</p> | | |

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

PRINTED: 02/01/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------------|
| 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 156} | Continued From page 8 residents' physicians. She was unclear on when she called them and said she did not document the contact. She then gave the paperwork to the Administrator. On 1/19/18 at 7:45 AM, the Administrator stated each manager was assigned to contact the resident's RP or POA via phone, and the name and contact information of the resident's physician. The Administrator provided a list of all the residents names residing in the facility with initials by each name. The Administrator stated the initials meant the staff member notified the RP or POA and circled the name and contact information of the physician on a Medical Director Information Letter. The Administrator was unable to provide further documentation that the facility contacted the RP or POA. | {F 156} | | | |
| {F 280} SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. | {F 280} | | 1/30/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 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 280} | Continued From page 9 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. | {F 280} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------------------------------------------------|
| 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 280} | <p>Continued From page 10</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 1 of 6 residents (#2) reviewed for care plan revisions and created the potential for harm when the care plan contained conflicting direction regarding call light availability. Findings include: Resident #2 was admitted to the facility on 3/1/16 with diagnoses, including Alzheimer's disease and muscle weakness. The quarterly Minimum Data Set assessment, dated 11/10/17, documented Resident #2 was</p> | {F 280} | <p>F280</p> <p>Resident #2 Comprehensive Care Plan and In-Room Care Plan was reviewed and updated to reflect the resident's current needs.</p> <p>Comprehensive Care Plans and In Room Care Plans have been reviewed and updated to reflect current care needs of in-house residents.</p> <p>The RCM's have been educated on the importance of updating care plans. Care plans will be reviewed and updated during</p> | | |

| | | | | |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 01/19/2018 |
| 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 280} | <p>Continued From page 11</p> <p>severely cognitively impaired, received hospice care, and was dependent on 2 staff for assistance with bed mobility and incontinence care.</p> <p>The current Hospice care plan, dated 11/4/17, directed staff that Resident #2 was to have a call light while in bed.</p> <p>The current Falls care plan, dated from 11/10/17 to 1/19/18, directed staff that Resident #2 was unable to use the call light and the call light was to be removed to avoid injury.</p> <p>From 1/18/18 at 1:55 PM through 1/19/18 at 6:00 AM, Resident #2 was observed in her bed 5 times with a bulb style call light accessible to her.</p> <p>On 1/19/18 at 7:22 AM, CNA #1 (Certified Nurse Assistant) said she always clipped the call light to the bed and placed Resident #2's call light in bed with the resident.</p> <p>On 1/19/18 at 7:52 AM, CNA #2 said she clipped the call light to the bed and placed Resident #2's call light in bed with the resident.</p> <p>On 1/19/18 at 8:10 AM, the DON (Director of Nursing) provided an updated Falls care plan, dated 1/19/18 at 7:18 AM and said when the surveyor had requested the care plan that morning, she realized the 11/10/17 call light portion of the care plan should have been removed. She said she had not noticed the contradictions in the care plan until the surveyor requested it and said the care plan should have been revised earlier.</p> | {F 280} | <p>AM MACC meeting as needed.</p> <p>The DNS or designee will review 3 charts / week x 4 weeks, then 1 chart per week x 4 weeks for completeness and review and revision of care plans. The DNS will report findings to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> | |