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June 10, 2019

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

Provider #: 135110

Dear Mr. Deloach:

On **June 14, 2018**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint#ID00007781

ALLEGATION #1

There was no heat in the rooms.

FINDINGS #1

During the investigation observations were conducted for environmental issues, Resident Council Meeting minutes and facility grievance were reviewed, six resident's records were reviewed, maintenance logs were reviewed, and multiple residents and staff were interviewed regarding environmental concerns.

Resident Council meeting minutes and grievances did not document concerns with lack of heat in rooms.

The Maintenance/Housekeeping Log documented no problems or concerns with a lack of heat in rooms. Multiple residents were interviewed and stated the heat in their rooms worked well and they had no concerns.

The Maintenance Director stated when a resident had concerns of equipment failure such as a heater not working, as soon as he was notified he would address the issue.

One resident's record did not contain documentation of their heater not working in their room.

Based on the investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility staff did not shower a resident who to change their clothes after a back surgery.

FINDINGS #2:

During the investigation observations were conducted for therapy services and ADL assistance, Resident Council Meeting minutes and facility grievance were reviewed, four resident's records were reviewed, and multiple residents and staff were interviewed regarded therapy services and ADL assistance.

Resident Council meeting minutes and grievances did not document concerns with therapy services and ADL assistance.

Multiple residents were interviewed and stated they had no concerns therapy services and ADL assistance. Residents stated the staff provided assistance with ADLs the first day they were admitted to the facility following knee, back, and or shoulder surgery.

One resident's record did not contain documentation of concerns with therapy services and ADL assistance.

Based on the investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3

The facility was unclean and without housekeeping on the weekends.

FINDINGS #3:

During the investigation observations were conducted for environmental issues, Resident Council Meeting minutes and facility grievance were reviewed, six resident's records were reviewed, maintenance logs were reviewed, housekeeping schedules and time cards were reviewed, and multiple residents and staff were interviewed regarded environmental concerns.

Resident Council meeting minutes and grievances did not document concerns with lack of housekeepers on the weekends and a dirty facility.

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Multiple residents were interviewed and stated their rooms were cleaned on a daily basis and they had no concerns. The residents were admitted to the facility for at least 2 years.

The Maintenance Director stated when a resident had concerns of equipment failure such as a heater not working, as soon as he was notified he would address the issue.

One resident's record did not contain documentation of complaints of the facility being dirty.

Based on the investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence

ALLEGATION #4:

Resident call lights were not answered in a timely manner.

FINDINGS #4:

During the investigation observations were conducted, Resident Council meeting minutes were reviewed, facility grievances were reviewed, staff were interviewed, and resident and family members were interviewed.

During observations of call light response by staff no concerns were identified. The call lights were answered within a timely manner and resident needs were taken care of before call lights were turned off by staff during the survey observations.

Resident Council Meeting minutes and grievances from December 2017 to March 2018, documented call light response times were an issue. The Resident Council meeting minutes and grievances from April to June 2018, documented call light response times were no longer a concern and the facility had corrected the concern.

Residents and two family members said call lights were answered in a timely manner and resident needs were met for the last few months. Residents stated a few months back the call light times were horrible and they had to wait for extended periods of time to get their call lights answered and their needs met. The residents stated the facility had hired new staff members to answer call lights during high demand times. CNAs and nurses said call lights were answered timely and they met the resident needs when they responded to the call light.

The Director of Nursing and the Administrator said call lights were answered timely and resident needs were met. The Director of Nursing and the Administrator stated they had hired CNAs to answer call lights at high demand times and residents had not voiced more concerns.

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Based on the investigative findings the allegation was substantiated, but no deficient practice was cited due to the facility correcting the identified concerns.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

Staff did not treat residents in a dignified manner in the dining room.

FINDINGS #5:

During the investigation observations were conducted for of the dining room for dignity, Resident Council meeting minutes were reviewed, facility grievances were reviewed, staff were interviewed, and resident and family members were interviewed.

During observations of the dining room no concerns were identified. The staff interacted with the residents and held conversations with them. The residents' meals were provided and staff assisted the residents who required assistance.

Resident Council meeting minutes and grievances did not document concerns with staff treatment and dignity in the dining room.

Residents and two family members said staff were respectful and appropriate in the dining room and they had no concerns.

The Director of Nursing and the Administrator said if a staff was disrespectful to a resident in the dining room they were coached on how to present themselves in the dining room.

Based on the investigative findings the allegation could not be substantiated.

ALLEGATION #6:

The facility inappropriately handled a death with regards to a roommate and accessing her room.

FINDINGS #6:

During the investigation observations were conducted throughout the facility, Resident Council meeting minutes were reviewed, facility grievances were reviewed, and resident, staff, and family members were interviewed regarding significant changes to a resident including death.

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During observations staff interacted with residents appropriately.

Resident Council meeting minutes and grievances did not document concerns with staff treating residents disrespectfully following the death of a resident.

Staff members were interviewed and stated they asked a roommate to leave the room if the other resident passed way so the facility could prepare the body and clean up the body. The staff stated this was done to respect the dignity of the individual who passed away. The staff stated they offered another area to the roommate while this was completed and let them back into their room once this was completed.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj