



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

August 2, 2018

Robert Deloach, 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. Deloach:

On **July 24, 2018**, 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** completion date for each federal and state tag in column (X5) Completion Date to signify when

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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 **August 15, 2018**. Failure to submit an acceptable PoC by **August 15, 2018**, may result in the imposition of civil monetary penalties by **September 6, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 28, 2018**, (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 28, 2018**. A change in the seriousness of the deficiencies on **August 28, 2018**, 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 28, 2018**, includes the following:

Denial of payment for new admissions effective **October 24, 2018**.
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 **January 24, 2019**, 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 **July 24, 2018**, 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:

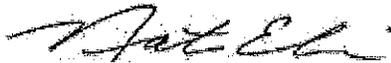
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 15, 2018**. If your request for informal dispute resolution is received after **August 15, 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, 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

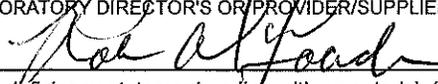
Printed: 08/01/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2018
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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V(111) structure, originally constructed in 1989. The structure is two hour separated from the common area of the adjacent independent living facility and incorporated two-hour rated wall and fire door assembly added in 2014, for a proposed expansion of the facility's accompanying Assisted Living occupancy.</p> <p>The facility is fully protected by an automatic sprinkler system with an interconnected fire alarm, including smoke detection in open spaces and corridors. The Emergency Power Supply System (EPSS) generator, is natural gas fired, located in the Independent Living occupancy and is equipped with an annunciator and remote manual stop. Currently the facility is licensed for 66 SNF/NF beds with a census of 59 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on July 24, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Health Care Occupancies, in accordance with 42 CFR 483.470.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire, Safety and Construction</p>	K 000	<p>RECEIVED</p> <p>AUG 17 2018</p> <p>FACILITY STANDARDS</p>	
K 325 SS=D	<p>Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101</p> <p>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</p>	K 325		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 8/14/18	(X6) DATE
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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 325	<p>Continued From page 1</p> <ul style="list-style-type: none"> * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * 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 * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure manual or automatically operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations and in accordance with the standard, has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During review of facility maintenance and inspection records conducted on 7/24/18 from approximately 9:30 - 10:00 AM, maintenance</p>	K 325 K 325	<p>Micro clean contacted immediately to set up replacement of all eight ABHR dispensers with non-alcohol based dispensers in the hallways. Completed 7/25/18</p> <p>All residents have the potential to be affected by these ABHR dispensers and all other hallway wall dispensers were checked to ensure that no further dispensers are alcohol based. No further dispensers found. Completed 7/24/18</p> <p>An environmental audit will be conducted weekly x4, then monthly x3, and then quarterly to include monitoring and checking all hallway wall dispensers to ensure that only non-alcohol based hand sanitizers are present in wall dispensers.</p> <p>The results of environmental audits will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting.</p> <p>Responsibility: Maintenance Director/designee.</p>	08/28/2018

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K 325	<p>Continued From page 2</p> <p>records provided for the refilling of ABHR dispensers failed to indicate what procedures were performed during the refill process. When interviewed on the ABHR dispenser refilling procedure, the Maintenance Director the facility had replaced the alcohol based sanitizers with non-alcohol based units.</p> <p>2) During the facility tour conducted on 7/24/18 from 3:00 - 4:00 PM, observation of the Lounge area and adjacent offices/utility support spaces, revealed eight (8) manually activated dispensers had been installed in the corridor. Asked about these dispensers and why they had not been documented for refilling, the Maintenance Director stated these were in the process of being replaced for the non-alcohol variety, but the change had not been completed.</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>	K 325		

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K 325	Continued From page 3 (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. (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.	K 325		

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K 325	Continued From page 4 (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 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 364 SS=D	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are	K 364		

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K 364	<p>Continued From page 5 no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor walls were absent of transfer grilles and would resist the passage of smoke. Installation of transfer grilles which expose interior wall cavities, has the potential to allow smoke, fire and dangerous gases to pass between compartments. This deficient practice affected 10 residents, staff and visitors in 1 of 5 smoke compartments on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/24/18 from approximately 3:00 - 4:00 PM, observation of an electronic care monitor mounted on the corridor wall at the Beauty Salon, revealed the wall behind the monitor had an approximately eight inch by sixteen inch transfer grille over a hole in the wall membrane of similar size, exposing the interior of the wall cavity.</p> <p>When asked about the hole and the transfer grille installed, the Maintenance Director stated the installation was prior to his tenure at the facility, but appeared to have been put in place to cover a conduit which supplied power to the electronic care monitor.</p> <p>Actual NFPA standard:</p> <p>19.3.6.4 Transfer Grilles. 19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link-operated dampers, shall not be used in corridor walls or doors.</p>	K 364 K 364	<p>The transfer grill that resulted in an opening in the fire wall near the beauty shop was removed and blocked off with 5/8" fire rated dry wall, which was patched and painted.</p> <p>Completed 7/25/18</p> <p>All resident have the potential to be affected by any break in the fire wall. All hallways where the electronic care monitors were placed were assessed and identified. Two other grilles were removed and blocked off with 5/8" fire rated dry wall, which was patched and painted.</p> <p>Completed 8/6/18</p> <p>An environmental audit will be conducted weekly x4, then monthly x3, and then quarterly to check all areas of the building that potentially could have a break in the fire wall.</p> <p>The results of environmental audits will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting.</p> <p>Responsibility: Maintenance Director/designee.</p>	08/28/2018

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K 923 K 923 SS=E	Continued From page 6 Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced	K 923 K 923 K923	Idaho Medical Supply was immediately contacted to remove all improperly stored oxygen cylinders that were stacked and not secured in the oxygen storage room. All tanks that were mixed together were separated and placed properly and secured. Completed 7/24/18 All residents have the potential to be affected by improper storage of oxygen cylinders, no harm resulted to any resident. Idaho Medical Supply provided an extra empty oxygen storage rack. New signs were made to be more visible to ensure separation of oxygen cylinder tanks between full and empty tanks. Completed 7/25/18 An audit of the oxygen storage room will be completed weekly by central supply to ensure compliance of proper storage and separation of the oxygen cylinders. The results of environmental audits will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting. Responsibility: Maintenance Director/designee.	08/28/2018

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K 923	<p>Continued From page 7</p> <p>by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate full and empty cylinders and secure all positive pressure medical gas cylinders by a rack or chain, has the potential of using incorrect cylinders during an emergency requiring supplemental oxygen and expose residents to the risks of explosions from falling or damaged cylinders. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 7/24/18 from approximately 3:00 - 4:00 PM, observation of the oxygen storage area outside the east exit of the lounge, revealed the following:</p> <p>Five (5) 'A' cylinders were identified by the Director of Nursing as "full", but were stored in the same horizontal rack as identified "empty" 'E' cylinders.</p> <p>Eight (8) 'E' cylinders were stacked loosely on top of a row of five (5) other cylinders, which were also stacked in the horizontal rack referenced above.</p> <p>Interview of the Director of Nursing established that she was not aware empty and full oxygen cylinders were intermixed and not being secured to prevent them from falling.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>5.1.3.3.2* Design and Construction. Locations for</p>	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2018	
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K 923	<p>Continued From page 8</p> <p>central supply systems and the storage of positive-pressure gases shall meet the following requirements:</p> <p>(1) They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1.</p> <p>(2) They shall be secured with lockable doors or gates or otherwise secured.</p> <p>(3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits.</p> <p>(4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating.</p> <p>(5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations.</p> <p>(6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required.</p> <p>(7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty.</p> <p>(8)*They shall be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 6.</p> <p>(9) They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials.</p> <p>(10) They shall protect electrical devices from physical damage.</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p>	K 923		

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

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FORM APPROVED
OMB NO. 0938-0391

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K 923	Continued From page 9 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure continuing education and staff training was provided on the risks associated with the storage, handling and use of medical gases and their cylinders. Failure to provide training of safety and the risks associated with medical gases, potentially increases risks associated and hinders staff response with the use and handling of oxygen. This deficient practice potentially affected oxygen dependent residents, staff and visitors on the date of the survey. Findings include: During review of provided training records on 7/24/18, records provided did not demonstrate continuing training was performed for the risks associated with oxygen and its use, only initial training conducted at orientation.	K 926		

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K 926	Continued From page 10 Interview of 3 of 3 staff members revealed none had participated in a facility provided, continuing education program, on the risks associated with the storage, handling or use of medical gases such as oxygen. During interview, when asked what training program the facility implemented on the risks associated with oxygen, the Staff Development Coordinator stated the facility did not have that training in place. Actual NFPA standard: NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926 K926	Idaho Medical Supply was immediately contacted to set up Oxygen safety training for all staff involved in managing oxygen use and storage. Completed 7/24/18 All resident have the potential to be affected by staff not maintaining knowledge of oxygen use and storage, none harmed. Oxygen safety training was provided on 8/8/18 to staff that is involved in the management of oxygen and will be completed with all staff involved in oxygen safety. Oxygen safety training will be added to the facilities required annual education schedule to be performed every August. Completed by 8/28/18 Random audits will be completed on staff that are involved with oxygen management to ensure oxygen knowledge weekly x4, then monthly x3, then quarterly. The results of environmental audits will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting. Responsibility: Staff Development Coordinator.	08/28/2018	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

August 2, 2018

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

Provider #: 135110

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Deloach:

On **July 24, 2018**, an Emergency Preparedness 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 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. 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** 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).

Robert Deloach, Administrator
August 2, 2018
Page 2 of 4

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 15, 2018**. Failure to submit an acceptable PoC by **August 15, 2018**, may result in the imposition of civil monetary penalties by **September 6, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 28, 2018**, (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 28, 2018**. A change in the seriousness of the deficiencies on **August 28, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 28, 2018**, includes the following:

Robert Deloach, Administrator
August 2, 2018
Page 3 of 4

Denial of payment for new admissions effective **October 24, 2018**.
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 **January 24, 2019**, 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 **July 24, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

Robert Deloach, Administrator
August 2, 2018
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Go to the middle of the page to Information Letters section and click on State and select the following:

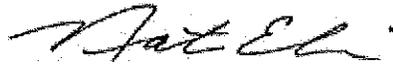
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 15, 2018**. If your request for informal dispute resolution is received after **August 15, 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, 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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651
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E 000	<p>Initial Comments</p> <p>The facility is a single story type V(111) structure, which is located in a municipal fire district with county and state EMS support services available. The structure has a two hour wall separating 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, for a proposed expansion of the facility's accompanying Assisted Living occupancy.</p> <p>The facility is fully protected by an automatic sprinkler system with an interconnected fire alarm, including smoke detection in open spaces and corridors. The Emergency Power Supply System (EPSS) generator, is natural gas fired, located in the Independent Living occupancy and is equipped with an annunciator and remote manual stop. Currently the facility is licensed for 66 SNF/NF beds with a census of 59 on the date of the survey.</p> <p>The following deficiencies were cited during the annual Emergency Preparedness survey conducted on July 24, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire, Safety and Construction</p>	E 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 17 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p>	
E 006 SS=D	<p>Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan</p>	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark L. Frach</i>	TITLE <i>8/14/18</i>	(X6) DATE
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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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E 006	Continued From page 1 that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to develop an Emergency Preparedness program that included a relevant facility based and community based risk assessment. Failure to provide a relevant facility and community based risk assessment, has the potential to focus staff training and resources on hazards that are not site specific. This deficient practice affected 59 residents, staff and visitors on the date of the survey.	E 006 E006	Risk factors were reevaluated in the facility assessment to include a more relevant ranking of local, or site specific emergencies the facility or community could potentially face. Completed 7/31/18 All residents, staff, and visitors have the potential to be affected by inadequate risk assessment. Site specific safety training will begin 8/14/2018 for all employees and be ongoing throughout the year. Site specific safety training will also be added to the facility's required annual education schedule to be performed every August. Completed by 8/28/18 Random quizzes will be completed on staff at the facility to ensure their knowledge of the plan: weekly x4, then monthly x3, then quarterly. The results of the safety plan quizzes, as well as additional training resources will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting. Responsibility: Staff Development Coordinator/Maintenance Director.	08/28/2018	

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E 006	Continued From page 2 Findings include: 1) On 7/24/18 from 10:00 - 10:30 AM, review of the provided emergency plan, policies and procedures, revealed the facility HVA (Hazard Vulnerability Analysis) provided information of the impact of Hurricanes and Tsunami's, which are not geographically relevant to the facility. Review of the county all-hazard mitigation plan for the area found no indication Hurricanes or Tsunami's were a likely occurrence for the geographical region. 2) On 7/24/18 from 1:00 - 1:30 PM, interview with the Maintenance Director revealed he was not aware these risks were included as part of the HVA. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006			
E 018 SS=D	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the	E 018			

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E 018	Continued From page 3 specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	E 018 E018	A Shelter In Place (SIP) log section was added to the emergency preparedness binder at each nurses' station in order to record the potential transfer of residents and visitors to other sections of the facility in the event of an emergency. Completed 7/31/18 All residents, staff, and visitors have the potential to be affected if the facility shelters in place due to an emergency. Shelter in place safety training will begin 8/14/2018 for all employees and be ongoing throughout the year. Shelter in place safety training will also be added to the facility's required annual education schedule to be performed every August. Completed by 8/28/18 Random nurses and aides will be quizzed at the facility to ensure their knowledge of the SIP log: weekly x4, then monthly x3, then quarterly. Responsibility: Staff Development Coordinator/Maintenance Director.	08/28/2018

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E 018	<p>Continued From page 4</p> <p>*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.</p> <p>*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered staff and patients has the potential to hinder continuity of care and essential services during an emergency. This deficient practice has the potential to affect the 59 residents, staff and visitors in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 7/24/18 from 10:00 - 10:30 AM, review of provided emergency plan, policies and procedures, failed to demonstrate the facility had in place a system to track the location of on-duty staff and residents sheltered in the facility during an emergency.</p> <p>Reference: 42 CFR 483.73 (b) (2)</p>	E 018			
E 026 SS=D	<p>Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the</p>	E 026			

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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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E 026	<p>Continued From page 5</p> <p>emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>(8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.</p> <p>*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHC! under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to document their role under an 1135 waiver as declared by the Secretary and the provisions of care as required under this action if identified by emergency management officials. Failure to plan for alternate means of care and the role under an 1135 waiver has the potential to limit facility options during an emergency. This deficient practice potentially affects reimbursement and continuity of care for the 59 residents, staff and visitors housed on the date of the survey along with the available surge needs of the community during a disaster.</p> <p>Findings include:</p> <p>On 7/24/18 from 10:00 -10:30 AM, review of the</p>	E 026 E026	<p>The instructions to requesting a CMS 1135 waiver have been included in the Emergency Preparedness Plan.</p> <p>Completed 8/13/18</p> <p>All residents have the potential to be affected by an 1135waiver. The waiver is to be submitted to CMS if additional licensed capacity is required as a result of an emergency. Training will begin on 08/14/2018 and be ongoing to senior management staff regarding the waiver and how to apply.</p> <p>Completed by 8/28/18</p> <p>Responsibility: Administrator/Maintenance Director.</p>	08/28/2018	

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E 026	Continued From page 6 provided emergency plan, policies and procedures, did not demonstrate the role of the facility under the declaration of an 1135 waiver, should that condition be enacted by the Secretary. Interview of the Maintenance Director revealed he was not aware the facility had included any policies or procedures on the role assumed by the facility under an 1135 waiver. Reference: 42 CFR 483.73 (b) (8)	E 026			
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide policies, procedure or plan identifying the method of sharing information on the emergency plan with residents, families or representatives. Failure to share the emergency plan and its contents with residents, families or representatives has the potential to create confusion and lack of understanding of the facility's response during a disaster. This deficient practice potentially affected 59 residents, staff and visitors on the	E 035 E035	A training and testing program has been developed and added to All-Staff, Orientation, and all other group training programs throughout the building for the Emergency Preparedness Plan Completed 8/14/18 All residents, staff, and visitors have the potential to be affected by inadequate Emergency Preparedness training. The site specific safety training will begin 8/14/2018 for all employees and be ongoing throughout the year. Residents' families will also be made aware of the facility's Emergency Preparedness Plan at admission and the 72 hour care conference. Site specific safety training will also be added to the facility's required annual education schedule to be performed every August. Completed by 8/28/18		

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E 035	Continued From page 7 date of the survey. Findings include: On 7/24/18 from 10:00 - 10:30 AM, during review of provided emergency plan, policies and procedures, no documentation was provided demonstrating the facility policy and method for sharing information with residents, their families or representatives on the contents of the emergency plan, or the facility's procedures during such events. When asked, the facility Maintenance Director stated he did not know of any policy or procedure included in the plan for family notification on the EP contents. Reference: 42 CFR 483.73 (c) (8)	E 035	Random Quizzes will be given to staff at the facility to ensure their knowledge of the plan: weekly x4, then monthly x3, then quarterly. Random audits will be performed on admission packets and 72 hour care conference files to ensure compliance: weekly x4, then monthly x3, then quarterly. The results of the safety plan quizzes and audits, as well as additional training resources, will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting. Responsibility: Staff Development Coordinator/Maintenance Director.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,	E 036		08/28/2018

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E 036	<p>Continued From page 8</p> <p>policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to provide an emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 59 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 7/24/18 from 10:00 - 10:30 AM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current testing program for staff based on training conducted on the contents of the emergency plan.</p>	E 036 E036	<p>A training and testing program has been developed and added to All-Staff, Orientation, and all other group training programs throughout the building for the Emergency Preparedness Plan</p> <p>Completed 8/14/18</p> <p>All residents, staff, and visitors have the potential to be affected by inadequate Emergency Preparedness training. The site specific safety training will begin 8/14/2018 for all employees and be ongoing throughout the year. Site specific safety training will also be added to the facility's required annual education schedule to be performed every August.</p> <p>Completed by 8/28/18</p> <p>Random quizzes will be completed on staff at the facility to ensure their knowledge of the plan: weekly x4, then monthly x3, then quarterly.</p> <p>The results of the safety plan quizzes, as well as additional training resources will be reviewed in the routine Quality Assurance Performance Improvement (QAPI) meeting.</p> <p>Responsibility: Staff Development Coordinator/Maintenance Director.</p>	08/28/2018

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

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E 036	Continued From page 9 Interview of the Staff Development Coordinator (SDC) established the facility had not yet implemented a testing program for staff on the contents of the Emergency Plan. Reference: 42 CFR 483.73 (d)	E 036			