

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

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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 12/20/2018
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}	<p>INITIAL COMMENTS</p> <p>From December 19, 2018 to December 20, 2018, an onsite revisit and complaint survey was conducted to verify correction of deficiencies noted during the survey of September 14, 2018, Karcher Post-Acute & Rehabilitation Center was found to be in substantial compliance with federal health care regulations as of October 15, 2018.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill, RN</p>	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

01/03/2019

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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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June 19, 2019

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

Provider #: 135110

Dear Mr. Deloach:

On **December 19, 2018** through **December 20, 2018**, two surveyors conducted an unannounced on-site complaint survey at Karcher Post-Acute & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007948

ALLEGATION #1:

The facility failed to provide pain medication to residents as ordered by the physician.

FINDINGS #1:

Six residents with pain issues were interviewed and observed for signs and symptoms of pain. The Medication Administration Records (MAR) of two residents receiving pain medications were reviewed. The records of two residents who received pain medication were reviewed. Three staff members were interviewed. Grievances, Incidents and Accidents, Reportable Investigations, and Resident Council meeting notes were reviewed for the past three months.

Six of six interviewed residents stated they had no concerns or issues regarding their pain or pain medication. Resident Council meeting notes from 11/26/18 documented medications were on time. The MAR of two residents documented pain medications were administered according to physician's orders. The record of one resident documented two pain medications were ordered, and one medication was not available from the pharmacy until the next day after he was admitted. The pain medication was ordered from the pharmacy on the same day the resident was admitted, and when the medication did not arrive from the pharmacy by the next morning a facility staff member called the pharmacy. The staff member was told it was a medication the pharmacy would have to special order because it was a new medication and not widely used. The pharmacy would have the medication sent from the nearest pharmacy as soon as it was available. The resident was given a dose of the secondary pain medication (tramadol) at 9:18 PM on the day of admission. His pain was rated 9/10 prior to the pain medication and he was sleeping after the medication was given, indicating the medication was effective. There was documentation he was asleep during the night and did not complain of pain again until 4:30 AM the next morning. The resident was given another dose of the secondary pain medication at 4:41 AM, approximately 7 hours after the first dose. His pain was rated as 10/10 prior to the medication and 5/10 after the medication was administered. The primary medication (Nucenta) arrived from the pharmacy, and the resident was provided with a dose of the primary pain medication at 9:26 AM.

The facility's investigation documented the resident's pain medications were ordered from the pharmacy on the day he was admitted. The nurse requested the pharmacy to send the medications by satellite pharmacy and was told by the pharmacy the medications would be sent that evening. The resident was given tramadol at 9:19 PM and "slept through the night." The resident was given another dose of tramadol at 4:41 AM with moderate relief. The nurse contacted the pharmacy and asked for the Nucenta to be sent as soon as possible. The resident stated the night before his pain level was 4/10 and it was well controlled until the next morning.

Based on the investigative findings, the allegation could not be substantiated, and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Facility staff did not answer residents' call lights, resulting in a resident self-transferring and using the bathroom unassisted.

FINDINGS #2:

Four residents were interviewed regarding call light response times, including three residents who needed assistance to the bathroom. Call light response times were observed and monitored at various times on various shifts, including morning, afternoon, and night. Grievances, Incidents and Accidents, Reportable Investigations, and Resident Council meeting notes were reviewed for the past three months. Staffing levels were reviewed.

Four interviewed residents said there were no concerns with call lights being answered or with being assisted to the bathroom. Call lights were answered by staff within one to four minutes. A grievance filed on behalf of the resident documented call light response times were monitored and documented and were found to be acceptable. The Resident Council meeting notes documented a concern regarding answering call lights in a timely manner in September 2018. The Resident Council meeting notes documented call light response times in October 2018 were good and no concerns with call light response times in November 2018. There were no other documented concerns regarding call light response. Staffing levels were found to be sufficient for the facility's census.

Based on the investigative findings, the allegation could not be substantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Facility staff failed to administer the correct dosage of blood pressure medication.

FINDINGS #3:

The MARs of four residents who received blood pressure medication were reviewed. Two nurses were interviewed and were observed administering blood pressure medication to a total of three residents. The clinical record of one resident who received blood pressure medication was reviewed.

The reviewed MARs of four of four residents documented the blood pressure medications were administered as ordered. Two of two nurses verbalized and demonstrated verification of the correct dosage of blood pressure medications and administered the correct dose to three of three residents.

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The clinical record of one resident documented he was admitted to the facility with an order from the hospital for Losartan 50 mg-hydrochlorothiazide 12.5 one tablet every evening for hypertension, and Losartan-hydrochlorothiazide 100-25 mg tablet daily. The resident's MAR documented the nurse provided the correct dosage of Losartan-hydrochlorothiazide in the morning, the MAR matched the physician's order, and the resident refused the medication.

The facility's investigation documented the resident's orders from the hospital included the blood pressure medication Losartan-hydrochlorothiazide 50-12.5 mg one tablet in the evening and Losartan-hydrochlorothiazide 100-25 mg one tablet in the morning, and the order was followed

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to serve food at an acceptable temperature.

FINDINGS #4:

Resident Council meeting notes and grievances were reviewed for the past three months. Five residents were interviewed. A meal test tray was reviewed, the food items were tasted, and the temperature of each food item was measured.

There were no documented concerns or grievances regarding food temperatures. Five of five interviewed residents said the food was hot or warm, it was not cold. The food items on the test tray tasted hot and the temperature was measured at greater than 135 degrees for each food item.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Robert Deloach, Administrator
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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,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in black ink and is positioned above the typed name.

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj