



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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January 24, 2020

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

Provider #: 135110

Dear Mr. Deloach:

On **January 10, 2020**, a survey was conducted at Karcher Post-Acute & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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.

**NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **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.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 3, 2020**. Failure to submit an acceptable PoC by **February 3, 2020**, may result in the imposition of penalties by **February 26, 2020**.

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

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

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

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 14, 2020 (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 **April 10, 2020**. A change in the seriousness of the deficiencies on **February 24, 2020**, 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 **April 10, 2020** includes the following:

Denial of payment for new admissions effective **April 10, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **July 10, 2020**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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 **April 10, 2020** 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 **February 3, 2020**. If your request for informal dispute resolution is received after **February 3, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

bd/lj

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

PRINTED: 02/19/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/10/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>KARCHER POST-ACUTE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
(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 federal recertification and complaint survey conducted on January 6, 2020 to January 10, 2020.  The surveyors conducting the survey were:  Presie Billington, RN, Team Coordinator Sallie Schwartzkopf, LCSW Carmen Blake, RN  ADL = Activities of Daily Living CNA = Certified Nursing Assistant DNR= Do Not Resuscitate DNS = Director of Nursing Services LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set POST = Physician Scope of Treatment RCM = Resident Care Manager RN = Registered Nurse SSD = Social Services Director	F 000			
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16)  §483.10(g) Information and Communication. §483.10(g)(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.  §483.10(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 and in writing in a language that the resident	F 572		2/21/20	

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

TITLE

(X6) DATE

Electronically Signed

02/03/2020

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

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F 572	<p>Continued From page 1</p> <p>understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of facility's Admission Packet, and staff interview, it was determined the facility failed to ensure residents were fully informed of their rights in the facility. This was true for 14 of 14 (#2, #3, #7, #8, #9, #16, #23, #26, #28, #34, #38, #40, #41, and #47) sample residents residing in the facility, and the other 42 residents living in the facility. This deficient practice created the potential for residents' rights to be violated without the residents' knowledge. Findings include:</p> <p>The facility's Admission Packet included an undated document which specified the residents' rights. The document did not include all the residents' rights included under 42 CFR 483.10, of the Long Term Care Facility federal regulations. Examples include:</p> <p>a. The right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research if the access was available to the facility and at the residents' expense if additional expense is incurred by the facility. This right is found at F575 [42 CFR 483.10(g)(5)].</p>	F 572	<p>#1 - Residents: 2, 3, 7, 8, 9, 16, 23, 26, 28, 34, 38, 40, 41, and 47 were affected by this deficiency. All residents residing in the facility may be affected by this deficiency.</p> <p>#2 - Facility corrected and updated the admission packets for the issues cited in the deficiency. Packets will be redistributed to each resident currently in the facility or mailed to the responsible DPOA where applicable.</p> <p>#3 <input type="checkbox"/> Periodically (weekly x 4, monthly x 3, and quarterly thereafter) admission documentation will be reviewed for completion, accuracy, consistency, and CMS compliance by the admission coordinator. An audit tracking sheet will be maintained.</p> <p>#4 <input type="checkbox"/> This practice will be tracked through the facility QA/PI committee for long term compliance by reviewing the tracking sheet created by admissions for any changes made to the admission packet, resident rights disclosures, or other</p>		

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F 572	<p>Continued From page 2</p> <p>b. The right to examine the results of the facility's most recent standard survey and that the facility must post notice of the availability of such reports during the 3 preceding years and any plan of correction in effect, in areas of the facility that are prominent and accessible to the public. This right is found at F577 [42 CFR 483.10(g)(10)(11)].</p> <p>c. The right to access personal and medical records upon an oral or written request in the form and format requested by the individual, or if not, in a readable hard copy form, within 24 hours. This right also states the facility must allow the resident to obtain a copy of the records upon request, and 2 working days advance notice to the facility. This right is found at F573 [42 CFR 483.10(g)].</p> <p>The facility's Admission Packet documented the facility would provide a copy or summary of residents' health information, usually within 30 days of the request.</p> <p>d. The right to refuse transfers to another room in the facility if the purpose of the transfer is to relocate the resident solely for the convenience of the staff. This right is found at F560 [42 CFR 483.10(e)(7)].</p> <p>The facility's Admission Packet documented "To be transferred or discharged only in accordance with transfer or discharge rules."</p> <p>On 1/9/20 at 3:38 PM, the Administrator said the facility provided residents' records within 24-48 hours of the request. The Administrator said the 30 days referenced in the Admission Packet was for special cases, such as when the resident</p>	F 572	<p>pertinent information subject to change. An electronic copy is available for editing purposes with a backup also available on a dedicated thumb drive kept by the admissions coordinator.</p> <p>Person responsible will be the Administrator or Admission Coordinator.</p>		

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F 572	Continued From page 3 required the records for legal purposes. The Administrator said he would contact the corporate office and request the updated Resident Rights.	F 572			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)  §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the results of the facility's most recent recertification survey	F 577	#1 - All residents in the facility could be affected by this deficiency.	2/21/20	

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F 577	Continued From page 4 was in a place readily accessible for review. This failed practice had the potential to impact the 56 residents residing in the facility, and all visitors who used the entrance to the facility located in the TV common area. Findings include:  On 1/8/20 at 8:17 AM, the Administrator said there were two entrances into the building, at the main entrance (remotely located) which also served as the entrance to an attached assisted living facility, and another in the TV common area (frequently used) of the long term care facility. At the time of the interview, the survey results binder was observed at the main entrance in a hard pocket, open at the top, and mounted at 5'-0" from the floor; it was not accessible to residents in wheelchairs. A copy of the facility's most recent recertification survey, completed on 9/14/18, was not observed in the TV common area which was used by most residents, and was the facility entrance used by most visitors. The Administrator said he understood the survey results binder mounted at 5'-0" from the floor was not accessible to residents sitting in a wheelchair. The Administrator said he would ask that the facility's recertification survey results be transferred to a location where it could be accessible to both residents and visitors.	F 577	#2 - The facility maintains the Prior Survey Results Binder at the main entrance of the Skilled Nursing Facility (station C) at a height range between 48 and 60, which is consistent with the Americans With Disabilities Act. This entrance is clearly labeled as the Skilled Nursing and Post Acute Rehabilitation entrance and is separate from the Independent or Assisted living entrances to the campus.  The facility does believe the binder could potentially be too high at 60 inches for everyone utilizing a wheelchair to reach.  #3 - Facility Maintenance Director immediately moved the brackets holding the binder closer to 48 inches from the floor in order to make access to the binder easier for everyone in a wheelchair to access.  #4 <input type="checkbox"/> Facility Maintenance Director will continue to monitor and seek feedback for residents wishing to examine the Prior Survey Results Binder.  Person responsible for the correction is the Administrator and Maintenance Director.		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		2/21/20	

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F 578	Continued From page 5  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff	F 578	#1 <input type="checkbox"/> Residents #8 and #16 were		

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F 578	<p>Continued From page 6</p> <p>interview, it was determined the facility failed to ensure residents' advance directive information was periodically reviewed with the residents and/or their representatives and was accurate. This was true for 2 of 6 residents (#8 and #16) whose records were reviewed for advanced directives. This failed practice created the potential for harm if the resident's documented wishes were not accurate and up-to-date regarding their advance directive information. Findings include:</p> <p>The Centers for Medicare and Medicaid Services State Operations Manual, Appendix PP, defines an "Advance directive" is "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST [POST] paradigm form is not an advance directive."</p> <p>The facility's Advance Directive policy, dated 3/2019, documented the following:</p> <p>*Upon admission written information was provided to residents or their representatives of their rights to make decisions concerning medical care, including the right to request, refuse and/or</p>	F 578	<p>affected by this deficiency and All residents in the facility could be affected by this deficient practice. Both residents are currently residing in the facility. Resident #16's Advance Directives were obtained. Social Services staff will re-attempt contact the resident #8's DPOAs to obtain the advance directives. Resident #8's family will be re-invited to a care conference where the Advance Directives can be discussed and formulated. In the event the DPOA chooses not to attend, voice mail, e-mail, and self-addressed stamped postage paid correspondence will be re-initiated and documented until the Advance Directives are obtained.</p> <p>#2 - Every effort is extended to obtain both DPOA documents outlining financial and healthcare powers granted in the advance directives at admission, during the initial 24-hour care conference, subsequent care conferences, via e-mail, conventional postal mail, and telephone conversations and voice mail. Facility will continue to document unsuccessful attempts to get healthcare DPOA documents and Advance Directives when dealing with uncooperative family or residents.</p> <p>#3 - Education will be given to SSD, and assistant in how to obtain DPOA documents and Advance Directives, what the differences are between POST and Advance Directives, and how to document the process (and unsuccessful</p>		

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F 578	<p>Continued From page 7</p> <p>discontinue medical or surgical treatment, and the right to formulate an advance directive.</p> <p>*If the resident had an advance directive, the facility requested a copy and kept it in the resident's medical chart accessible to the physician and facility staff.</p> <p>*If the resident did not have an advance directive, the facility offered assistance to the resident if they wished to formulate an advance directive. If the resident was incapacitated, advance directive information was provided to the resident's representative.</p> <p>*The facility reviewed quarterly, annually, and during significant changes in condition, the resident's decision-making capacity, and invoked the health care agent or legal representative if the resident was determined not to have decision making capacity.</p> <p>a. Resident #8 was admitted to the facility 7/22/19, and again readmitted on 9/19/19, with multiple diagnoses including myasthenia gravis (an autoimmune disease that causes weakness in the skeletal muscles, which are responsible for breathing and moving parts of the body, including the arms and legs) and hypertension (high blood pressure).</p> <p>A quarterly MDS assessment, dated 10/22/19, documented Resident #8 had severe cognitive impairment.</p> <p>Resident #8's care plan, documented her advance directive was reviewed, was on file, and reflected her current wishes.</p>	F 578	<p>attempts) to obtain such documents.</p> <p>#4 - Audits for medical records for weekly x 4, monthly x2, and quarterly as need as well as QAPA for long term compliance monitoring.</p> <p>Responsible person is Administrator or SSD designee.</p>		

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F 578	Continued From page 8  Resident #8's record included a Durable Power of Attorney (DPOA) related to managing her finances and property and a Physician Orders for Scope of Treatment (POST) form which documented a code status of DNR and was signed by her representative on 7/22/19. Resident #8's record did not include a copy of a DPOA for healthcare.  b. Resident #16 was admitted to the facility on 8/5/19, with multiple diagnoses including heart failure and dementia.  A quarterly MDS assessment, dated 9/15/15, documented Resident #16 had severe cognitive impairment.  Resident #16's care plan, documented her advance directive was reviewed, was on file, and reflected her current wishes.  Resident #16's record included a copy of a DPOA for financial and property management and a POST form which documented a code status of DNR and was signed by her representative on 8/19/15. The DPOA document stated the powers granted to the DPOA did not include healthcare decision making.  On 1/8/19 at 8:56 AM, SSD said the Social Services Assistant discussed advance directives with the residents and/or their representatives during their care conferences. The SSD said if the resident had an advance directive a copy was requested and kept in the resident's file. If the residents did not have an advance directive they offered them assistance to complete one. The	F 578			

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F 578	Continued From page 9 SSD reviewed the DPOA documents for Resident #8 and Resident #16 and said they were DPOAs for financial services and not DPOAs for healthcare. The SSD said she started working in the facility about three months ago. The SSD said when the care plans for Resident #8 and Resident #16 documented their advance directives were discussed, it might have meant their POST forms were discussed.	F 578			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		2/21/20	

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F 585	Continued From page 10 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,	F 585			

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F 585	Continued From page 11 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure grievances were responded to and investigated, and prompt corrective action was taken to resolve the grievances. This was true for 1 of 1 resident (Resident #37) reviewed for grievances. This failure created the potential for harm if residents' verbal grievances were not investigated and corrective action taken, if necessary. Findings	F 585	#1 <input type="checkbox"/> Resident #37 was affected by this deficiency. This deficiency could adversely affect the safety and wellbeing of every resident in the facility. Resident #37 was reimbursed by the business office for the lost funds.  #2 - When a grievable situation is brought up to facility staff, the facility will document the occurrence and, with the		

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F 585	<p>Continued From page 12 include:</p> <p>The facility's Policy and Procedure for Grievances, dated 3/2019, documented:</p> <ul style="list-style-type: none"> <li>* Concerns/grievances could be presented verbally or in writing and could include lost personal items, or violation of rights.</li> <li>* The facility was to actively seek resolution to concerns and attempt to keep the individual who filed the grievance updated on progress toward resolution.</li> <li>* The facility was to have a designated Grievance Officer who was responsible for overseeing the grievance process, receiving, investigating, tracking grievances through to their conclusion and maintain the confidentiality of all information associated with grievances.</li> <li>* The Social Services Director/Designee or any staff member was to assist concerned resident(s) with completing a Grievance/Concern Form. If the person with concern did not want to complete a Grievance Form, any format was accepted.</li> <li>* The Social Services Director/Designee was to log all concerns/grievances received onto the facility grievance log.</li> <li>* The concern/grievance was to be reviewed and assigned to the appropriate department head at the facility daily stand up meeting or as appropriate.</li> <li>* Grievances were to be completed with appropriate actions and follow-up.</li> </ul> <p>This Policy was not followed.</p> <p>Resident #37 was initially admitted to the facility on 3/17/19, and readmitted on 12/20/19, with multiple diagnoses including sepsis (the body's overwhelming and life-threatening response to</p>	F 585	<p>resident's permission, initiate the grievance process. Depending on the event, and whether the situation can be immediately rectified, the resident will be asked if they would like to file a grievance by the staff member taking their complaint, or report of the grievable issue. That employee can initiate the grievance, instruct the resident how to fill out the form, or instruct the resident's family or concerned party, regarding the proper method to complete the form. If a resident would like to file a grievance and would also like a staff member to complete the form, any staff are obliged to assist them. Staff can also initiate the grievance process even if the resident does not wish to file an official grievance for whatever personal reasons they may have.</p> <p>The grievance form is then passed to the appropriate department head for investigation and review. If the appropriate department head is not readily available, or if there is a question as to who the appropriate investigator would be, the grievance form and materials will be given to the facility administrator. Investigation and conclusions/findings will be completed within the allotted time frame. The grievance resolution is then presented to the resident or interested party for review. If the resident or concerned party is satisfied with the outcome, they may sign the form certifying they agree with the findings and remedies. The form and</p>		

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F 585	<p>Continued From page 13</p> <p>infection that can lead to tissue damage, organ failure, and death), pneumonia, chronic obstructive pulmonary disease (COPD - progressive lung disease characterized by increasing breathlessness), and intestinal obstruction.</p> <p>Resident #37's MDS Quarterly Assessment, dated 12/17/19, documented he was cognitively intact and his vision was adequate.</p> <p>On 1/6/19 at 9:17 AM, Resident #37 said he had money removed from his wallet twice but did not report it the first time. He said \$3 was taken the first time and \$5 the second. He said \$5 was removed from the closed zippered compartment of his wallet on Thursday, 1/2/20. He said he told the RN the next day, Friday, 1/3/20, who said they would tell the right person. He said he was yet to talk to the right person.</p> <p>No documentation of Resident #37's missing money was found in the Grievance binder for January 2020.</p> <p>On 1/8/20 at 1:56 PM, RN #1 said if a resident told her they were missing an item, she reported the missing item to Social Services and the Unit Manager and asked the CNAs if they saw the missing item.</p> <p>On 1/8/20 at 2:47 PM, SSD said she took grievances, and if an item was not found the facility reimbursed the resident. She said a resident could have requested any staff to fill out a grievance form and help them with it, or they could fill out their own grievance, and at times they filled out a statement form. She said there</p>	F 585	<p>supporting materials will be filed in the grievance binder.</p> <p>If a resident or interested party do not wish to file a grievance, it is still the responsibility of the facility to investigate and potentially correct the complaint or rectify a deficient practice as the occurrence may adversely affect other residents, family members, or staff. Every effort will be made to record a concerned party's wishes if they do not wish to file a grievance in the grievance log under "Does Not Wish to File Grievance." That occurrence will still be evaluated and communicated through management communication channels for continual training and improvement.</p> <p>Additionally, random resident satisfaction interviews will be conducted monthly in order to discover grievable occurrences that may not have been initially reported.</p> <p>#3 - Staff will be re-educated as to the policy and procedure regarding grievances, and who the grievance officer is at Karcher Estates.</p> <p>#4 - The grievance process, as well as the binder, will be audited weekly x4, monthly x 2, and quarterly as needed <input type="checkbox"/> as well as monitored in QA/PI for long term compliance by the Social Services Director.</p>		

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F 585	Continued From page 14 were many people and many ways for a resident to express a concern, and the SSD was not expected to be the only person filing grievances and investigating. When asked who the point person was for grievances, the SSD said she held the Grievance binder "so I guess I am that person". SSD said she had not been aware Resident #37 was missing money, and she would get a grievance form and talk with Resident #37 and the Unit Manager.  On 1/10/20 at 8:17 AM, RN #1 said Resident #37 told her he was missing some money and she told a Social Services staff person.  The facility did not ensure Resident #37's concern was documented and acted upon in a timely manner.	F 585	Responsible person to ensure compliance will be the SSD/Administrator or designee.		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		2/21/20	

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F 622	<p>Continued From page 15</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this</p>	F 622			

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F 622	<p>Continued From page 16</p> <p>section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure required information was provided to the receiving facility when a resident was transferred to the hospital. This was true for 2 of 2 residents (#8 and #102) reviewed for transfers. This deficient practice had the potential to cause harm if the residents were not treated in a timely manner due to lack of information. Findings</p>	F 622	<p>#1-For resident #8 and #102 documentation did not reflect what paperwork was sent with the resident which did not follow the Policy of the facility.</p> <p>#2-All residents that require transfer/discharge to the hospital have the potential to be affected of the information</p>		

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F 622	<p>Continued From page 17 include:</p> <p>The facility's Notice of Transfer or Discharge policy and procedure, dated 3/2019, documented when the facility transfers or discharges a resident, the appropriate information is communicated to the receiving care institution or provider. At a minimum the following information is provided:</p> <ul style="list-style-type: none"> <li>* Contact information of the practitioner responsible for the care of the resident.</li> <li>* Resident representative information, including contact information.</li> <li>* Advance Directive information.</li> <li>* Special instructions or precautions for ongoing care.</li> <li>* Comprehensive Care Plan goals.</li> <li>* Other necessary information including a copy of the discharge summary. Such as, resident needs that cannot be met and facility attempts to meet those needs.</li> </ul> <p>This policy was not followed.</p> <p>1. Resident #102 was admitted to the facility on 12/2/19, with multiple diagnoses including pneumonitis (inflammation of lung tissue) due to inhalation of food and vomit, acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues), developmental disorder of speech and language, and Parkinson's disease (a progressive nervous system disorder that affects movement).</p> <p>Resident #102's MDS discharge assessment, dated 12/17/19, documented he was severely cognitively impaired, and he had an unplanned</p>	F 622	<p>to be provided to the receiving facility. The licensed nurses re-educated regarding regulatory requirements and facility policy on information to be sent with the resident when being sent to the hospital; notifications to the resident's care provider, the responsible party, and the Emergency room; and proper documentation in the progress notes to include reason for transfer to the hospital, what paperwork was sent to the hospital, notifications of physician and family, Advanced Directives, special instructions in the care of the resident through the transfer form, and that the Emergency Room triage nurse has been notified and given a report.</p> <p>#3-During the morning Managing Acute Condition Change (MACC) meeting, the DNS and RCMs will audit/review progress notes, and transfer forms of any resident that was sent out to the hospital for accuracy of the documentation to meet the requirements. This will ensure no other resident will be adversely affected.</p> <p>#4-Audit findings will be reported and reviewed by the QAPI committee monthly x3 months then quarterly to identify opportunities for performance improvement.</p> <p>DNS/designee will be responsible for compliance with this practice.</p>		

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F 622	<p>Continued From page 18 discharge to the hospital.</p> <p>Resident #102's medical record did not include documentation information was provided to the receiving hospital.</p> <p>On 1/10/20 at 9:00 AM, Medical Records Staff #1 said a transfer form was not completed for Resident #102's transfer to the hospital. She said RCM #1 said she had been helping another resident at the time. Medical Records Staff #1 provided the Transfer Packet and Post-Acute to Acute Emergency Transfer forms used by the facility which were to be completed and sent with a resident to the hospital. This information was not documented in Resident #102's record.</p> <p>On 1/10/20 at 2:30 PM, RCM #1 said she did not complete a transfer form for Resident #102, as she was busy with another resident.</p> <p>2. Resident #8 was admitted to the facility 7/22/19, and readmitted on 9/19/19, with multiple diagnoses including myasthenia gravis (an autoimmune disease that causes weakness in the skeletal muscles, which are responsible for breathing and moving parts of the body, including the arms and legs) and hypertension (high blood pressure).</p> <p>A discharge MDS assessment, dated 9/13/19, documented Resident #8 was discharged to a hospital with anticipated return to the facility.</p> <p>A Nurse's Progress Note, dated 9/13/19 at 5:48 PM, documented Resident #8 had nausea and vomiting with yellow colored emesis, and poor appetite. Resident #8 was confused and weak,</p>	F 622			

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NAME OF PROVIDER OR SUPPLIER  <b>KARCHER POST-ACUTE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
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F 622	Continued From page 19 made her needs known and answered questions appropriately. The progress note also documented Resident #8 requested to be taken to the hospital.  A Nurse's Progress Note, dated 9/14/19 at 12:22 AM, documented Resident #8 was sent to the hospital via non-emergency transport at 7:00 PM on 9/13/19.  Resident #8's record did not include documentation information was provided to the receiving hospital.  On 1/8/19 at 12:47 PM, LPN #2 said if a resident needed to be transferred to the hospital she gave the discharge papers/documents to the paramedics. LPN #2 said she never documented what discharge papers/documents were sent to the hospital with the resident.  On 1/8/19 at 1:19 PM, the DNS said the facility sent the face sheet, physician's orders, POST, MAR, History and Physical Examination, laboratory results and bed hold notice when a resident was transferred to the hospital. The DNS said she did not see documentation in Resident #8's record of what information was sent with her when she was transferred to the hospital.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		2/21/20	

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F 623	<p>Continued From page 20</p> <p>language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p>	F 623			

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F 623	<p>Continued From page 21</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure</p>	F 623			

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F 623	<p>Continued From page 22</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure transfer notices were provided in writing to residents and their representatives. This was true for 1 of 2 residents (Resident #8) reviewed for transfers. This created the potential for harm if residents or their representatives were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy and procedure for Notice of Transfer or Discharge, dated 3/2019, documented when the transfer or discharge was initiated, the resident received written notice using the Resident Notice of Transfer or Discharge. The Resident Notice included the following items:</p> <ul style="list-style-type: none"> <li>* Date notice was given</li> <li>* Effective date of the transfer/discharge</li> <li>* Reason for the transfer/discharge</li> <li>* Where the resident was to be moved</li> <li>* Contact information for the State Long Term Care Ombudsman</li> <li>* Contact information for the protection and advocacy agency for residents with an intellectual disability, developmental disability, or</li> </ul>	F 623	<p>#1-For resident #8 the resident <input type="checkbox"/>s responsible party was notified at time of transfer to the hospital via phone call due to change of condition, as daughter lives out of state and documented as such. There was no written transfer notice provided as resident was being sent in an emergent situation and resident is not cognitively aware to understand this information. Resident did know that she was being transferred to the hospital as it was her request.</p> <p>#2- All residents that require transfer/discharge to the hospital have the potential to be affected. The licensed nurses re-educated regarding regulatory requirements and of the appropriate Notice of Transfer/Discharge form present in the Electronic Medical Record form section and review of completion of this form.</p> <p>#3- During the morning Managing Acute Condition Change (MACC) meeting, the DNS and RCMs will audit/review the forms to ensure that the Notice of</p>		

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F 623	<p>Continued From page 23</p> <p>other related disability</p> <p>* Explanation of the right to appeal the transfer or discharge</p> <p>* The name, address, and telephone number of the State entity which received appeal hearing requests</p> <p>Resident #8 was admitted to the facility on 7/22/19, and readmitted on 9/19/19, with multiple diagnoses including myasthenia gravis (an autoimmune disease that causes weakness in the skeletal muscles, which are responsible for breathing and moving parts of the body, including the arms and legs) and hypertension (high blood pressure).</p> <p>A discharge MDS assessment, dated 9/13/19, documented Resident #8 was discharged to a hospital.</p> <p>A Nurse's Progress Note, dated 9/13/19 at 5:48 PM, documented Resident #8 had nausea and vomiting with yellow colored emesis, and poor appetite. Resident #8 was confused and weak, made her needs known and answered questions appropriately. The progress note also documented Resident #8 requested to be taken to the hospital.</p> <p>A Nurse's Progress Note, dated 9/14/19 at 12:22 AM, documented Resident #8 was sent to the hospital via non-emergency transport at 7:00 PM on 9/13/19.</p> <p>On 1/8/20 at 12:47 PM, LPN #2 said she informed Resident #8's representative of the transfer to the hospital verbally via phone.</p>	F 623	<p>transfer/discharge form was completed with any resident being discharged. Medical Records will audit all discharged resident for completion of the Notice of Transfer/Discharge form is complete and in the resident's file.</p> <p>#4-Audit findings will be reported and reviewed by the QAPI committee monthly x3 months then quarterly to identify opportunities for performance improvement.</p> <p>DNS/designee, Medical Records will be responsible for this practice.</p>		

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F 623	Continued From page 24 On 1/8/20 at 1:19 PM, the DNS said Resident #8's record did not include documentation a written transfer notice was provided to her representative when she was transferred to the hospital.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		2/21/20	

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F 625	<p>Continued From page 25</p> <p>Based on staff interview, policy review and record review, it was determined the facility failed to ensure a bed hold notice was provided to residents and their representatives upon transfer to the hospital. This was true for 1 of 2 residents (Resident #8) reviewed for transfers. This deficient practice created the potential for harm if residents and their representatives were not informed of the residents' right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's Bed Hold policy, dated 3/2019, stated upon transfer a copy of bed hold policy was provided to the residents and/or their responsible party. If the copy of the bed hold notice was not provided the Social Services Director should contact the resident and/or their representative to notify them of the facility's policy.</p> <p>This policy was not followed.</p> <p>Resident #8 was admitted to the facility 7/22/19, and readmitted on 9/19/19, with multiple diagnoses including myasthenia gravis (an autoimmune disease that causes weakness in the skeletal muscles, which are responsible for breathing and moving parts of the body, including the arms and legs) and hypertension (high blood pressure).</p> <p>A discharge MDS assessment, dated 9/13/19, documented Resident #8 was discharged to a hospital.</p> <p>A Nurse's Progress Note, dated 9/13/19 at 5:48 PM, documented Resident #8 had nausea and</p>	F 625	<p>#1 Resident #8 was sent to the hospital without documented verbal or written review of the bed hold policy.</p> <p>#2-All residents that require transfer/discharge to the hospital have the potential to be affected by appropriately receiving Bed Hold policy information. The licensed nurses will be re-educated regarding regulatory requirements and facility policy on providing information regarding Bed Hold Policy when being transferred to the hospital.</p> <p>#3-During the morning Managing Acute Condition Change (MACC) meeting, the DNS and RCMs will audit/review progress notes, and the Bed Hold policy form of any resident that was sent out to the hospital for completion of bed hold form and documented in the progress notes to meet the requirements. This will ensure no other resident will be adversely affected. Medical Records will audit any resident transferred to the hospital to ensure that there is a Bed Hold policy form signed in the resident's medical record.</p> <p>#4- Audit findings will be reported and reviewed by the QAPI committee monthly x3 months then quarterly to identify opportunities for performance improvement.</p> <p>DNS/designee, Medical records will be responsible for this practice.</p>		

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F 625	Continued From page 26 vomiting with yellow colored emesis, and poor appetite. Resident #8 was confused and weak, made her needs known and answered questions appropriately. The progress note also documented Resident #8 requested to be taken to the hospital.  A Nurse's Progress Note, dated 9/14/19 at 12:22 AM, documented Resident #8 was sent to the hospital via non-emergency transport at 7:00 PM on 9/13/19.  Resident #8's record did not include documentation that a bed hold notice was provided to her and her representative when she was transferred to the hospital.  On 1/8/20 at 12:47 PM, LPN #1 said if a resident needed to be transferred to the hospital she sent the required medical record with the resident but not a bed hold notice. LPN #1 she did not find a bed hold notice in Resident #8's record.  On 1/8/20 at 1:19 PM, the DNS said a bed hold notice should be provided to the resident and the resident's representative upon discharge to the hospital.	F 625			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined	F 677	#1-Resident #8 was assessed to determine her continued ability to	2/21/20	

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F 677	<p>Continued From page 27</p> <p>the facility failed to ensure residents were assisted with hand hygiene and oral care consistent with their needs. This was true for 1 of 14 residents (Resident #8) reviewed for ADL care. This failure created the potential for harm by potentially exposing residents to the risk of infection, embarrassment and isolation. Findings include:</p> <p>Resident #8 was admitted to the facility on 7/22/19, and readmitted to the facility on 9/19/19, with multiple diagnoses including myasthenia gravis (an autoimmune disease that causes weakness in the skeletal muscles, which are responsible for breathing and moving parts of the body, including the arms and legs) and hypertension (high blood pressure).</p> <p>A quarterly MDS assessment, dated 10/22/19, documented Resident #8 had severe cognitive impairment and required extensive assistance of one staff member for personal hygiene.</p> <p>a. On 1/6/20 at 9:53 AM, Resident #8 was observed awake in her bed. When asked if the surveyor could see her teeth, Resident #8 opened her mouth and smiled at the surveyor. Resident #8's front lower teeth had whitish to brownish material in between the teeth. Resident #8 said she could not remember when she brushed her teeth.</p> <p>On 1/7/20 at 11:19 AM and on 1/8/20 at 10:45 AM, Resident #8's lower front teeth were observed to have whitish brownish material in between her teeth.</p> <p>On 1/8/20 at 11:12 AM, CNA #1 looked at</p>	F 677	<p>complete her oral care/personal hygiene at a set up/supervision level. Though the resident was capable, she had fluctuations of completing the task along with assisting her to perform hand hygiene after use of bathroom. Resident's care plan was reviewed and revised to be changed to limited assistance and a therapy referral was sent to be evaluated to determine her functional ability and promote highest independence in her ADL capability.</p> <p>#2-All residents have the potential to be affected by this, therefore all current in-house resident's care plan and their actual functional abilities were evaluated and updated with any noted changes along with a referral to therapy services for an evaluation. The licensed nurses and Certified Nursing Assistants were re-educated regarding providing the assistance to a resident for any task unable to be completed thoroughly by the resident themselves and to provide hand hygiene to all residents after use of the bathroom and any time that their hands are soiled. Re-educated also to notify the Resident Care Manager, Physician, responsible party, and therapy department of any changes in the resident's functional ability.</p> <p>#3-Random audits will be performed of 5 residents weekly x4, then monthly x3 then quarterly to include visual assessment of resident's ability to complete tasks as per care plan and notification to</p>		

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F 677	Continued From page 28 Resident #8's teeth and said Resident #8 did not look like she brushed her teeth. CNA #1 said she assisted Resident #8 to the restroom, set-up her tooth brush and put tooth paste on the tooth brush and left Resident #8 in the restroom. CNA #1 said she did not assist Resident #8 to brush her teeth.  On 1/8/20 at 4:20 PM, the DNS said CNA #1 should have checked Resident #8 to see if she brushed her teeth and assisted Resident #8 if she could not perform the task of brushing her teeth.  b. On 1/6/20 at 1:05 PM, Resident #8 was observed sitting on the toilet with CNA #2 standing next to her. Resident #8 then held onto the handle bar on the wall with her right hand and her left hand was holding onto her wheelchair to support herself as she stood up. CNA #2 wiped Resident #8's buttocks with a wipe and used another wipe to clean her genitalia. CNA #2 then applied a new incontinent brief to Resident #8 and assisted her to her wheelchair. CNA #2 washed her hands with soap and water and then wheeled Resident #8 to her overbed table where her lunch meal was set. Resident #8 was observed to take the fork by its tines and start eating lunch.  On 1/6/20 at 1:20 PM, CNA #2 said she washed her hands after assisting Resident #8 in the toilet, but she did not wash Resident #8's hands. CNA #2 said she forgot to wash Resident #8's hands.	F 677	appropriate team members, physician, and resident/responsible party with any noted changes.  #4 Audit findings will be reported and reviewed by the QAPI committee monthly x3 months then quarterly to identify opportunities for performance improvement.  DNS/designee will be responsible for this practice.		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care	F 684		2/21/20	

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NAME OF PROVIDER OR SUPPLIER  <b>KARCHER POST-ACUTE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
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F 684	<p>Continued From page 29</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure professional standard of nursing practice were followed for 1 of 14 residents (Resident #101) reviewed for standards of practice. Resident #101's blood glucose (blood sugar) was not checked when she displayed symptoms of possible hypoglycemia (when blood sugar levels have fallen low enough that action needs to be taken bring them back to target range). This failed practice placed Resident #101 at risk of dangerously low blood glucose levels. Findings include:</p> <p>The facility's Hyperglycemia and Hypoglycemia policy and procedure, dated 2/2019, documented shakiness, dizziness, sweating, and sudden behavior changes as some of the symptoms of hypoglycemia. The policy stated if the blood glucose level was 70 mg/dl (milligram/deciliter) and the resident was conscious, 15 grams of carbohydrates, such as one tablespoon of sugar or four ounces of fruit juice should be provided to the resident.</p> <p>Resident #101 was admitted to the facility on 9/12/19, with multiple diagnoses including diabetes mellitus and chronic kidney disease</p>	F 684	<p>#1-Resident #101 is no longer in the facility as was discharged. Licensed nurse was counseled regarding failure to follow standards of performing a Blood Glucose check on a resident that was potentially demonstrating symptoms of Hypoglycemia.</p> <p>#2-All residents that are Diabetic have the potential to be affected by this, therefore an audit conducted on any in-house Diabetic resident's interdisciplinary notes has been completed to determine any changes in condition noted, and an appropriate assessment of the resident was completed and documented to include a Blood Glucose level was performed, and to include notification of the physician of a change in the resident's condition. The licensed nurse was re-educated regarding Diabetes, signs and symptoms of Hypo/Hyperglycemia, facility policy, and appropriateness of checking the resident's Blood Glucose level with any change in the resident's condition. All LNs will be given the same inservice as well.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135110</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/10/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>KARCHER POST-ACUTE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1127 CALDWELL BOULEVARD NAMPA, ID 83651</b>		
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F 684	<p>Continued From page 30 stage 3 (moderate kidney damage).</p> <p>An admission MDS assessment, dated 10/10/19, documented Resident #101 was cognitively intact.</p> <p>Resident #101's September 2019 MAR documented she was to receive insulin as follows:</p> <p>*Levemir Flexpen 100 units/milliliters, inject 15 units subcutaneously every morning and at bedtime. *Novolog Flexpen 100 units/milliliters, inject 5 units subcutaneously before meals.</p> <p>A Nurse Practitioner's verbal order, dated 9/19/19, directed the staff to check Resident #101's blood glucose four times a day before meals and at bedtime for one week. Resident #101's September MAR documented her blood glucose levels were assessed as ordered, from 9/19//19 - 9/26/19. Resident #101's bedtime blood glucose levels were documented as assessed at 8:00 PM during the time period and ranged from 79 mg/dl to 242 mg/dl.</p> <p>A Nursing Progress Note, dated 9/30/19 at 10:33 PM, documented Resident #101 was shaking uncontrollably and it appeared to be like an uncontrolled shiver. The noted documented Resident #101 stated she felt like she had the flu. Resident #101's vital signs were assessed. Her blood pressure was elevated at 149/89, her respiratory rate was within normal limits at 22 breaths per minute, her temperature was slightly elevated at 99.5 degrees Fahrenheit (F), and her oxygen saturation was within acceptable range at</p>	F 684	<p>#3-During the morning Managing Acute Condition Change (MACC) meeting, the DNS and RCMs will audit/review progress notes to determine any change of condition in Diabetic residents that appear symptomatic to ensure a Blood Glucose level was performed and reported appropriately.</p> <p>#4 Audit findings will be reported and reviewed by the QAPI committee monthly x3 months then quarterly to identify opportunities for performance improvement.</p> <p>DNS/designee will be responsible with this practice.</p>		

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F 684	Continued From page 31 94%. The Nursing Progress Note documented the nurse administered PRN (as necessary) acetaminophen and directed the CNA to perform 30-minute checks on Resident #101. The Nursing Progress Note stated Resident #101's temperature was rechecked, and it was 98.9 degrees F and Resident #101 was coherent and sitting at the edge of her bed. The Nursing Progress Note also documented "Trembling is now less intense." There was no documentation Resident #101' blood glucose level was assessed.	F 684			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.  §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following	F 849		2/21/20	

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F 849	Continued From page 32 requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board	F 849			

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F 849	<p>Continued From page 33</p> <p>care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the</p>	F 849			

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F 849	Continued From page 34 provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each	F 849			

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F 849	<p>Continued From page 35 patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care was coordinated with a hospice provider and duties of the hospice provider and the facility were delineated. This was true for 1 of 4 residents (Resident #16) reviewed for hospice care. This failure created the potential for Resident #16 to receive inadequate care due to a lack of coordination between the facility and the hospice agency. Findings include:</p> <p>Resident #16 was admitted to the facility on 8/19/15, and readmitted on 8/5/19, with multiple diagnoses including heart failure and dementia.</p>	F 849	<p>#1-For resident #16 the resident's coordination of care document with a qualified hospice agency was not located in the medical record. Hospice was contacted and the coordination of care document was supplied.</p> <p>#2- All residents that require outside hospice services have the potential to be affected. Medical Records Personnel will be re-educated regarding regulatory requirements for the appropriate Hospice Coordination of Care documents to be present in the Medical Record.</p>		

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F 849	<p>Continued From page 36</p> <p>A significant change MDS assessment, dated 12/6/19, documented Resident #16 received hospice services.</p> <p>A Hospice progress note, dated 12/7/19, documented Resident #16 had a terminal diagnosis of protein calorie malnutrition and unspecific gastrointestinal hemorrhage.</p> <p>Resident #16's care plan, initiated on 12/7/19, documented she had a terminal diagnosis of protein calorie malnutrition and she received hospices services. The care plan did not include documentation of the responsibilities or care delineated between the facility and the hospice agency.</p> <p>On 1/8/20 at 9:54 AM, the DNS said she was unable to find documentation of delineation of duties between the facility and the hospice agency, so requested a copy of delineation of duties from the hospice agency on 1/7/20. The DNS then provided a copy of delineation of duties to the surveyor which was faxed to the facility on 1/7/20 at 2:57 PM.</p>	F 849	<p>#3- During the morning Managing Acute Condition Change (MACC) meeting, the DNS and RCMs will audit/review the Medical Records for all Hospice residents receiving services from outside, qualified agencies to ensure the Coordination of Care Documents are completed and included appropriately. Medical Records staff will regularly audit all Hospice residents' medical records for completion.</p> <p>#4-Audit findings will be reported and reviewed by the QAPI committee monthly x3 months then quarterly thereafter to identify opportunities for performance improvement.</p> <p>DNS/designee, Medical Records are responsible for this practice.</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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April 17, 2020

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

Provider #: 135110

Dear Mr. Deloach:

On **January 6, 2020** through **January 10, 2020**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008270**

**ALLEGATION #1:**

The facility failed to ensure medications were administered as prescribed.

**FINDINGS #1:**

During the survey residents' records and the facility's Grievance file and Resident Council minutes from July 2019 to December 2019 were reviewed and residents and staff were interviewed.

The facility's Grievance file and Resident Council minutes did not include grievances or concerns related to medications not being given in accordance with physicians' orders.

Seventeen residents' records, including 3 closed records (meaning the residents were discharged from the facility) were reviewed for quality of care concerns. Each of the records included physician medication orders. One resident's record included physician's progress notes which documented the resident's azithromycin was discontinued on 8/28/19 prior to the resident's admission to the facility. The physician's progress note also included an order for Albuterol 2.5. mg/ml solution to be given every 4 hours, and also as needed for wheezing.

Two licensed nurses were observed passing medications at different times on 1/9/20 and there were no concerns noted. A nurse was observed to administer Breo Ellipta (an inhaled respiratory medication used to treat obstructive pulmonary disease) to a resident and there were no concerns noted.

On 1/6/20 at 11:25 AM, 9 residents attended the group interview with the surveyors. The residents did not voice concerns regarding their medications. In addition to the group interview, 12 residents were interviewed individually. The residents stated they had no concerns with administration of their medications.

Based on the investigative findings it could not be determined the facility failed to ensure medications were administered as prescribed. Therefore, the allegation was unsubstantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility failed to notify resident representatives of changes in the residents' conditions.

#### FINDINGS #2:

During the investigation, Incident and Accident reports were reviewed, resident records were reviewed, staff were interviewed, and resident representatives were interviewed.

The facility's Incident and Accident reports, from July 2019 to January 2020 were reviewed. The reports reviewed included documentation the resident representatives were informed of incidents that had occurred.

For example, an Incident and Accident report dated 10/2019, documented a resident's representative was informed the resident had fallen. The resident's record included a Nurse's Progress Note, which documented the resident was found on the floor in front of her wheelchair. The note stated the resident used her wheelchair to walk and when she sat down in her wheelchair it moved and the resident slid down to the floor. There was no injury noted. Another Nurse's Progress Note, documented the Director of Nursing (DON) received a call from the resident's representative. The progress note documented the DON informed the resident's representative know that she would sit down with the resident's representative and review what had happened and give the representative a summary of the report.

The records of 13 other residents were also reviewed for notification of resident representatives of changes in residents' condition, and there were no concerns noted. Additionally, the facility's Grievance file and Resident Council minutes from July 2019 to December 2019 were reviewed. There were no documented concerns related to notification of residents' representatives. Five residents' representatives were interviewed and said they were notified by the facility. Based on the investigative findings it could not be determined the facility failed to notify resident representatives of changes in the residents' conditions. Therefore, the allegation was unsubstantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

The facility failed to ensure blood glucose was checked when diabetic residents displayed symptoms of possible hypoglycemia (low blood sugar).

#### FINDINGS #3:

During the investigation the records of four residents who were diagnosed with diabetes were reviewed.

One of the records included a Nurse's Progress Note which documented the resident was shaking uncontrollably. The resident's vital signs were assessed. Her blood pressure was elevated, her respiratory rate was within normal limits, her temperature was slightly elevated, and her oxygen saturation was within acceptable range. The resident received acetaminophen and the Certified Nursing Assistant was directed to perform a 30-minute check on the resident. When the resident's temperature was rechecked, it was within normal limits and the resident was coherent. There was no documentation in the Nurse's Progress Note the resident's blood glucose was assessed.

Robert Deloach, Administrator  
April 17, 2020  
Page 4 of 4

The DON was interviewed on 1/10/20 at 1:18 PM. The DON stated the resident had a diagnosis of diabetes mellitus, and the nurse should have checked the resident's blood glucose and she did not.

Based on the investigative findings it was determined the facility failed to ensure blood glucose was checked when a diabetic resident displayed symptoms of possible hypoglycemia. The allegation was substantiated and the facility was cited at F684 related to the failure to ensure blood glucose levels were monitored following professional standards of practice.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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



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April 17, 2020

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

Provider #: 135110

Dear Mr. Deloach:

On **January 6, 2020** through **January 10, 2020**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008298**

**Allegation #1:** Pain medications are not provided when residents request them.

**Findings #1:** An unannounced recertification and complaint survey was conducted from January 6, 2010 to January 10, 2020. During the survey residents records were reviewed, the facility's Grievance file was reviewed, Resident Council minutes were reviewed, and residents and staff were interviewed.

The facility's Grievance file and Resident Council minutes did not include documentation of concerns related to medications not being given as needed and in accordance with physicians' orders.

Two licensed nurses were observed passing medications at different times on 1/9/20 and there were no concerns noted.

Seventeen resident records, including 3 closed records (meaning the residents were discharged from the facility) were reviewed for concerns. Each of the records included physician medication orders and documentation medication was administered, including pain medications.

Two residents' medication administration records from December 2019 and January 2020 were reviewed. Both of the records documented the residents' pain needs were addressed, with both residents receiving ordered pain medications less than daily.

A third resident's medication administration records from November 2019 and December 2019 were reviewed. The records documented the resident had requested pain medication less frequently than daily and the medication was documented to be effective in relieving her discomfort. The resident was interviewed on 1/6/20 at 8:43 AM. The resident stated she had pain less than daily and currently did not have pain. The resident stated she received pain medication when she asked for it without a long wait.

On 1/6/20 at 11:25 AM, 9 residents attended the group interview with the surveyors. The residents did not voice concerns regarding their medications being administered timely. Additionally, 12 residents were interviewed individually. The residents stated they had no medication administration concerns.

Based on the investigative findings, it could not be determined the facility failed to ensure pain medications were administered when requested and as prescribed. Therefore, the allegation was unsubstantiated.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Call lights are not answered in a timely manner, privacy is not provided, and staff do not explain treatment and cares to the residents.

**Findings #2:** During the survey, observations were conducted, the facility's Grievance file and Resident Council minutes were reviewed, and residents were interviewed.

Call lights were observed on 1/6/20 at 1:30 PM and 2:30 PM. The call lights were answered in a timely manner with no wait time longer than 3 minutes.

During an observation on 1/9/20 at 11:40 AM, a resident turned on the call light. The Certified Nursing Assistant (CNA) responded to the resident in less than 1 minute. The resident reported she needed to use the toilet. The CNA stepped into the hallway and alerted another CNA that assistance was needed. A CNA placed a gait belt on the resident as he explained what he was doing. The CNAs used a gait belt and hand hold to assist the resident to the bathroom and they provided the resident with privacy. When

the resident verbally notified the CNAs she was finished, the CNAs entered the bathroom, assisted the resident with perineal care using the gait belt and hand hold, assisted the resident to wash her hands and ambulate back to her wheelchair.

When asked, the resident stated she had not experienced incontinent episodes due to waiting for assistance from staff. The resident's Power of Attorney was also interviewed on 1/8/20 at 11:46 AM. No complaints about the care and services provided to the resident were expressed.

During an observation of perineal care, dressing and oral care provided to another resident on 1/9/20 at 10:24 AM, 2 CNAs explained all the steps of what they were doing in an unhurried manner, including explaining what the resident could expect. The CNAs spoke directly to the resident and provided clear and unhurried explanation of the care as they performed perineal care and assisted the resident to get dressed. There were no concerns identified in the observation related to the resident being rushed or the CNAs failing to provide adequate information to the resident.

During another observation on 1/9/20 at 11:30 AM, a CNA assisted another resident to the toilet. The CNA allowed privacy and waited until the resident finished before going back into the bathroom. The CNA then assisted the resident to wash his hands and return to his wheelchair.

The facility's Grievance file and Resident Council minutes did not include grievances or concerns related to call lights not being answered in a timely manner, privacy not being provided or staff not explaining treatment and cares to the residents.

On 1/6/20 at 11:25 AM, 9 residents attended a group interview. The residents did not voice concerns regarding call lights not being answered in a timely manner. Twelve other residents were interviewed individually and none voiced concerns regarding privacy not being provided.

Based on the investigative findings, it could not be determined call lights were not answered in a timely manner, that privacy was not provided, or that staff did not explain treatment and cares to the residents. Therefore, the allegation was unsubstantiated.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** Residents are left in front of the television without staff interaction or assistance.

**Findings #3:** During the survey, observations were conducted, the facility's Grievance file was reviewed, Resident Council minutes were reviewed, and residents were interviewed.

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An observation was conducted when the building was entered on 1/6/20 at 8:10 AM. Multiple residents were seated in the common area, with the television on. Staff were observed assisting residents to their rooms after breakfast and providing care. Residents were assisted from the common area to their rooms or to an activity of their choice.

On 1/6/20 at 8:20 AM and 8:43 AM a resident was observed seated in a wheelchair at her bedside with headphones on and watching television. When asked, the resident stated that "everything" was fine, and she had no complaints regarding her care and services provided by the facility.

On 1/6/20 at 11:25 AM, 9 residents attended a group interview. The residents did not express concerns regarding being left in front of the television without staff interaction or assistance, or the facility not offering activities.

The facility's Grievance file and Resident Council minutes did not include grievances or concerns related to a lack of activities or staff not interacting with residents or assisting residents when needed.

Based on the investigative findings, it could not be determined residents were left in front of the television without staff interaction or assistance. Therefore, the allegation was unsubstantiated.

**Conclusion:** 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.

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/ac



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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April 22, 2020

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

Provider #: 135110

Dear Mr. Deloach:

On **January 6, 2020** through **January 10, 2020**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008326**

**ALLEGATION #1:**

The facility did not provide hydration using a method based upon a resident's needs.

**FINDINGS #1:**

During the investigation residents were observed, records were reviewed, and resident representatives and staff were interviewed.

Three residents were reviewed for nutrition and hydration, and no deficiencies were found.

One resident was admitted on 12/2/19 with multiple diagnoses including pneumonitis (inflammation in the air sacks of the lungs) due to aspiration (breathing food, saliva, or stomach contents when swallowing), developmental disorder of speech and language, Parkinson's disease, and other developmental disorders.

The resident's MDS Admission Assessment, dated 12/2/19, documented he required limited assistance with one-person physical assistance for eating. The assessment documented the resident exhibited a loss of liquids/solids from his mouth when eating or drinking, a sign of a possible swallowing disorder.

The resident's order summary report documented an order dated 12/2/19, the resident was to have a cardiac diet, a dysphagia mechanical soft diet (generally soft foods which do not require a lot of chewing) with moist foods that required some chewing, and "no straws." The order also documented the occupational therapist (OT) and speech therapist (ST) were to evaluate and treat the resident.

An OT evaluation and treatment plan, dated 12/2/19, documented the resident required stand by assistance with close supervision for the majority of self-feeding for safety, which may include set up but no physical contact, and one or more cues for the majority of the meal.

A speech language pathologist (SLP) Evaluation and Plan of Treatment form, dated 12/4/19, documented a recommendation for the resident to have thin liquids and close supervision for oral intake, and the resident and/or caregiver was to guide food and utensil placement, alternate liquids and solids, and to use no straws.

An ST treatment encounter note, dated 12/9/19, documented the resident performed swallows with thin liquids, with and without a straw. The note documented the resident demonstrated appropriate sips of liquid with cup drinking with no signs of symptoms of aspiration. The note also documented the resident needed frequent instruction with the use of a straw to take smaller amounts and to do multiple swallows to completely clear his oral cavity and pharynx.

An OT treatment encounter note, dated 12/10/19, documented the OT facilitated a discussion with the ST regarding a special diet as the resident coughed every time he drank water, and the ST responded the resident was to be on nectar thick liquids without straws, and informed the CNA staff.

On 1/9/20 at 12:11 AM, the Director of Rehabilitation and the current ST said the facility's regular ST moved out of state, and the facility used a traveling ST until they hired the current one. The Director said there was more consistency during the last couple of months with a permanent ST.

The permanent ST said she recommended no straw, because the resident did not have enough control, and with a straw the fluid would go to the back of his mouth too quickly and he would cough.

Based on the investigative findings, it was substantiated the facility used a method to administer fluids to a resident that was not based on his needs during an evaluation. However, no citations were issued as the facility corrected the error and there was no current deficient practice.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility did not provide rehabilitation services in a timely manner after a resident's admission and did not use the appropriate assistive devices for ambulation.

**FINDINGS #2:**

Five residents were reviewed for limited range of motion, activities of daily living, and falls and no deficiencies were found.

One resident was admitted on 12/2/19 with multiple diagnoses including pneumonitis, developmental disorder of speech and language, and other disorders. The resident was discharged on 12/17/19.

The resident's MDS Admission assessment, dated 12/2/19, documented he required extensive assistance of one person for ambulating, and the assistance of two persons for bed mobility and transfers. The assessment documented the resident was impaired on both upper and lower extremities and used a walker or wheelchair.

The resident's record documented a physician order on 12/2/19 for Physical Therapy (PT) to evaluate and treat the resident.

A PT evaluation, focusing on the resident's ambulation and treatment plan, dated the day of admission on 12/2/19, documented:

- The resident walked 0 minutes of the 5-minute walk test.
- The resident's upper range of motion (ROM) was impaired, and the resident was unable to mimic ROM positions, flex his shoulders > 90 degrees, and was unable to fully flex his elbows and move his fingers away from his body consistently.
- The resident said, "No, I'll fall," when instructed to try taking a few steps with a front-wheeled walker, and the resident's gait (walking) pattern was unable to be assessed due to the resident's refusal.
- The resident was dependent on assistance when walking and when wheeling the wheelchair.

A PT treatment encounter note, dated the day after admission on 12/3/19, documented the resident agreed to treatment and ambulated approximately 100 feet four times with contact guard assistance and demonstrated random crossing of the left foot needing minimum assistance to correct his balance.

There were subsequent PT treatment encounter notes which included the resident's progress to the date of his discharge on 12/16/19. The last note stated the resident walked 45 feet with a front-wheeled walker and 15% hand on assistance required.

During an interview, the PT said the facility assesses residents on the day of admission, and if they are admitted too late in the day they assessed the resident on the day after admission. She said they try to complete a full assessment, as much as the resident can tolerate, and if they refuse, they try to establish their needs for transfers and getting in and out of bed. She said they implement the plan as soon as possible, usually on the same day of admission. She said the resident's record indicated the PT evaluation was done on 12/2/19, and the OT evaluation was done on 12/3/19, and the ST evaluation was done on 12/4/19. She said the resident refused to walk on the first day. She said they did not do the gait assessment on 12/2/19. She said on 12/3/19 the resident walked 100 feet with contact guard with a gait belt and a walker. She said the resident always has a gait belt on to manage the walker when turning.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

The facility failed to ensure a resident did not become dehydrated or lose weight.

#### FINDINGS #3:

Three residents were reviewed for nutrition, hydration, and quality of care, and no deficiencies were found.

One resident's MDS Admission Assessment, dated 12/2/19, documented the resident required limited assistance with one-person assistance for eating. The assessment documented the resident exhibited a loss of liquids/solids from their mouth when eating or drinking; a sign of a possible swallowing disorder.

The resident's physician orders documented he was to be on a cardiac diet, a dysphagia mechanical soft diet (soft foods which do not require a lot of chewing) with most foods that are easy to chew, including pureed or pudding-like foods, and to avoid foods with coarse textures, and no straws. The orders also documented the occupational therapist and speech therapist were to evaluate and treat the resident.

The resident's record, dated 12/11/19 to 12/17/19, documented his eating and drinking were monitored three times a day.

The resident's weights and vital signs summary documented on 12/3/19, the day after his admission, the resident weighed 124.2 pounds, and on 12/16/19, the day before his discharge, the resident weighed 125.4 pounds.

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The resident's progress notes, dated 12/17/19, the day of discharge, documented the facility physician assistant (PA) documented the resident "possibly could have a viral illness, he declined with symptoms of generalized body aches, decreased oral intake, and increased weakness. The PA also documented intravenous (IV) access was attempted twice, and the resident pulled out his IV without successful fluid administration. The documentation stated the resident continued to have intermittent fevers, and developed diarrhea and staff were concerned about his condition. The PA also documented the resident appeared to be declining rapidly and due to the concern for dehydration, sepsis and electrolyte abnormality, the PA felt the resident would benefit from an emergent evaluation in the emergency room. The resident was discharged on 12/17/19 to a local hospital.

In an interview with a CNA, she said dehydration is addressed by offering residents fluids, making sure they have fluids, documenting the meal fluid consumption quantity, and how much extra residents consume in their room.

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.

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,



Belinda Day, RN, Supervisor  
Long Term Care Program

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