

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER Karcher Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1127 Caldwell Boulevard Nampa, ID 83651	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a resident's missing property was investigated and prompt corrective action was taken. This was true for 1 of 3 residents (Resident #28) whose missing items were reviewed. This failure created the potential for psychological harm if residents' missing items were not investigated. Findings include: The facility's Grievances/Complaints, Recording and Investigating policy, revised April 2017 documented all grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Resident #28 was admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including stroke, cancer of right retina (part of the eye) and dementia. A care plan dated 8/29/24, documented Lost glass eye, MD (physician) recommended to leave out. A care plan dated 2/28/24, documented Resident #28 had history of cancer to her right eye and it was removed. She wore a prosthetic which she kept removing and the physician recommended to leave the eye out as it was causing her more issues than doing her good. On 9/2/25 at 2:00 PM, the Social Services Director (SSD) stated if a resident had a missing item reported they would look for it and if not found the facility would replace the missing item. When asked about Resident #28's missing glass eye, as documented in her care plan, the SSD stated she started in the position as SSD in April of 2025 and worked as nurse in the facility prior to her being the SSD. The SSD stated she heard Resident #28 removed her glass eye, placed it on her meal tray and the meal tray was taken away. The SSD was asked to provide documentation Resident #28's missing glass eye was investigated or what action did the facility do to locate the missing glass eye. On 9/2/25 at 3:51 PM, the SSD together with the DON stated she was unable to locate documentation Resident #28's missing glass eye was investigated or acted upon.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2025
NAME OF PROVIDER OR SUPPLIER Karcher Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1127 Caldwell Boulevard Nampa, ID 83651	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the Long Term Care State Reporting Portal, Incident and Accident (I&A) report, record review and staff interview, it was determined the facility failed to provide an environment free from accidental hazards over which the facility has control and provides supervision to each resident to prevent avoidable accidents. This was true for 1 of 4 residents (Resident #36) reviewed for accidents. Resident #36 was harmed when a CNA failed to notify the nurse Resident #36 was using a heating pad. Resident #36 was found to have a burn at the hospital. Findings include: Resident #36 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including surgical amputation of the left leg above the knee, diabetes, kidney disease, depression, anxiety, chronic pain symptom, and hypertensive heart disease without heart failure. An annual MDS Assessment, dated 7/16/25, documented Resident #36 was cognitively intact. Resident #36's medications included, but was not limited to:- Duloxetine (an anti-depressant, and also used to treat chronic pain) HCL capsule delayed release particles, dated 7/12/25, give 60 mg by mouth for neuropathy and depression.- Pregabalin (an anticonvulsant also used to treat nerve pain) Oral Capsule, dated 8/26/25, 150 mg 1 capsule by mouth three times per day for phantom limb pain.- Oxycodone (narcotic pain medication) HCL oral tablet 5 mg by mouth every 6 hours for chronic pain. A review of an I&A, dated 8/27/25, documented Resident #36 was found unresponsive at 3:45 AM when RN #1 attempted to wake her up to take her 2:00 AM medications. RN #1 felt hot compresses under Resident #36's gown. RN #1 was unaware Resident #36 was using a heating pad, or that it was on. The report stated RN #1 was unaware if Resident #36 was using a heating pad, and was never told it was on, or if Resident #36 was able to use it. RN #1 attempted to cool Resident #36 down by rolling her towards her and removing the heating pad. RN #1 did not visualize the resident's back as she was alone while rolling Resident #36 towards her. RN #1 was focused on getting Resident #36's vitals taken and applying cold compresses to the resident. Resident #36's temperature was documented at 100 degrees [F], and cold compresses did not wake the resident. Additional staff were called to assist to take Resident #36's vital signs, and Resident #36 remained unresponsive. RN #1 decided to contact emergency services. When RN #1 returned to Resident #36's room, her blood pressure was unreadable, and her oxygen levels were significantly low. Resident #36 remained unresponsive while life-saving measures were offered. Emergency services arrived soon after and Resident #36 was sent to the hospital. The facility investigation documented, CNA #1 stated she had cared for Resident #36 at 9:00 PM [on 8/26/25] and was aware Resident #36 had a heating pad with a green fabric cover on it. CNA #1 stated she was unaware Resident #36 was not allowed a heating pad. Resident #36 had told CNA #1 she was cold. The I&A report further documented the DON was informed by Resident #36's daughter, Resident #36 had a large burn and was being sent to [a nearby city] for burn care. There was no documentation in Resident #36's record CNA #1 notified the nurse on duty Resident #36 had a heating pad in her room or that the heating pad was placed behind Resident #36. Nursing progress notes, dated 8/26/25 at 1:40 PM, documented a Late Entry note where Resident #36 was concerned with an area on her buttocks. Resident #36 was examined, and it was documented her skin area was clear and there were no skin issues at that time. On 9/3/25 at 10:27 AM, the DON stated CNA #1 saw the heating pad was behind Resident #36's back, but did not check to see if it was on or off. The DON stated CNA #1 should have reported the heating pad to the nurse, but she did not.</p>		