| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 135110 | A. Building<br>B. Wing | 11/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Karcher Post Acute | 1127 Caldwell Boulevard<br>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) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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 |
|---|---|---|
| | | |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure a resident was free from abuse. This was true for 1 of 3 residents (Resident #50) whose incidents during transferring were reviewed. This failure resulted in actual harm when Resident #50 was injured during a transfer from her bed to a wheelchair against her will. Findings include: The Centers for Medicare and Medicaid (CMS) State Operations Manual (SOM), Appendix PP, dated 7/23/25, defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful as defined in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Resident #50 was admitted to the facility on [DATE] with multiple diagnoses including dementia, history of stroke, history of fractures, and age-related osteoporosis (a bone disease that causes bones to become weak, fragile, and more likely to break).Resident #50's care plan included the following:- Initiated 3/1/24, Resident #50 is at risk for increased pain. Monitor/record/report to nurse any signs or symptoms of non-verbal pain: changes in breathing (noisy, deep/shallow, labored, fast/slow); vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); eyes (wide open/narrow slits/shut, glazed, tearing, no focus); face (sad, crying, worried, scared, clenched teeth, grimacing); body (tense, rigid, rocking, curled up, thrashing).- Initiated 2/28/24, Resident #50 is at risk for increased pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease in [range of motion], withdrawal, or resistance to care.- Initiated 2/28/24, Resident #50 was at risk for falls. For fall prevention: nonskid footwear when transferring.- Initiated 6/20/24, Resident #50 had a stroke, activity as tolerated, out of bed in chair if tolerated.- Initiated 11/24/24, Resident #50 was at risk for activities of daily living (ADL)/mobility decline and required assistance related to limited mobility, with documentation she was dependent on 2 staff for assistance with stand pivot transfers and to use a mechanical lift if she was tired.- Initiated 12/1/24, Resident #50 had a diagnosis of osteoporosis, with the goal Resident #50 will be free from complications of chronic pain, injury, infection, and increase in impaired physical mobility symptoms to extent possible, with staff direction to handle gently when turning/repositioning and with daily care.- Initiated 6/4/25, Resident #50 had impaired skin integrity, with staff direction to allow Resident #50 to initiated and transfer herself slowly to reduce amount of agitation with transfers.Resident #50's electronic health record documented an interdisciplinary team note, dated 6/6/25. The note documented Resident #50's representative requested staff education on transfers to reduce agitation and due to her history of fractures, the staff were educated she preferred slow transfers where she could move herself and she would hold onto staff or grab bars for assistance. The note documented Resident #50 did not like for others to move her.The facility's incident investigation report summary documented, on 7/12/25, Resident #50 suffered a fracture of unknown origin.The report documented Resident #50 would not get out of bed and they were able to finally get her up at about 12 [PM] and got her cleaned up changed and put her in her wheelchair. The investigation report documented, after [Resident #50] was placed in her [wheelchair] she started having what looked like seizure activity, signs of left side drooping in her face, and it was determined to go ahead and send her out to the emergency room for evaluation.The incident report included a staff statement, dated 7/13/25, Licensed Practical Nurse (LPN) #6 documented, On 7/11/25, I witnessed [Resident #50] in her wheelchair at 7:30 PM. The statement continued, During the night, I did not hear anything out of the ordinary. There was not a reported fall or complaint of pain during the shift. [Resident #50] remained in bed from 10:00 PM to 6:00 AM. I did hear [Resident #50] complain during final rounds, though did not hear well enough to tell what she was saying, and it is common for her to be upset when disturbed when she is asleep in bed.The incident report included a staff statement, dated 7/15/25, Certified Nurse Aide (CNA) #3 documented, I worked [the night shift] 7/11/25-7/12/25. I did assist [CNA #14] to complete cares two times. [Resident #50] was agreeable with cares and did not yell or hit CNA's. We let [Resident #50] lead her cares and assisted. No complaining of pain with cares. Just complained of being cold.The incident report included a staff statement, taken by the Director of Nursing (DON), from CNA #14 about 7/11/25, it documented, I changed [Resident #50 on 7/11] and she yelled for her mom and dad, and seemed scared but then went right back to sleep. She did not seem like she was in any pain.The incident report included a nurses note, dated 7/12/25 at 1:38 PM, LPN #10 documented, [Resident #50] slept in this morning. Staff attempted to help her out of bed this morning |

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| F 0760<br>Level of Harm - Actual harm<br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of Incidents and Accidents (I&A's) reports, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 8 of 8 residents (#4, #5, #6, #7, #8, #9, #10, and #11) reviewed for medication errors. Resident #4 was harmed after being administered her roommate's opioid pain medication and required medical intervention. Resident #5 was harmed when her narcotic medication was omitted resulting in increased pain. There was potential for harm and adverse outcomes when Residents #6, #7, #8, #9, #10, and #11's medications were not administered following physicians' orders. Findings include:The online Nursing 2025 Drug Handbook accessed on 11/10/25, stated the eight rights of medication administration were: - Right drug- Right patient- Right dose- Right time- Right route- Right reason- Right response- Right documentation 1. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including dementia, chronic obstructive pulmonary disease, and hypertension. The facility's Medication Error Report documented a medication error occurred at 7:30 AM on 8/1/25 when the nurse administered Resident #4 another resident's medication. Resident #4 was noted to be suffering from increased lethargy and drowsiness and wasn't acting like herself as a result of the error.The medication administered to Resident #4 was: oxycodone 7.5 mg (opioid pain medication).A physician's order dated 8/1/25, documented, place IV (intravenous catheter), NS (normal saline) 500 ml bolus (the rapid administration of a single, concentrated volume of fluid directly into a patient's bloodstream through a vein) and then 100 ml per hour for 5 hours to treat patient who was noted to have increased drowsiness and lethargy after patient was administered 7.5 mg oxycodone in error.On 11/7/25 at 12:40 PM, the DON confirmed on 8/1/25, the nurse administered another resident's medication to Resident #4 in error, and she required medical intervention due to the error. 2. Resident #5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnosis including fractured vertebra (multiple broken bones in the spine), malignant neoplasm of the lung (lung cancer), and low back pain.Resident #5's physician's orders, dated 7/31/25, documented, oxycodone 7.5 mg tablet by mouth every 4 hours as needed for pain.The facility's Medication Error Report documented a medication error occurred at 7:30 AM on 8/1/25 when Resident #5 did not receive her PRN (as needed) pain medication as requested.Resident #5 experienced increased pain when she did not receive the pain medication until 12:40 PM on 8/1/25, 5 hours after it was requested. Resident #5's pain monitoring on 8/1/25 documented as follows:-7:28 AM pain level 8 out of 10-12:35 PM pain level 9 out of 10In response to the missed PRN pain medication, a physician's order on 8/1/25 documented staff were to provide Resident #5 non-pharmacological interventions for pain management and administer PRN pain medication.On 11/7/25 at 12:42 PM, the DON confirmed the nurse did not administer Resident #5's dose of oxycodone as requested for pain, which resulted in untreated and increased pain. 3. Resident #6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including dementia, hypertension, and fibromyalgia (a disorder characterized by widespread pain accompanied by fatigue, sleep, memory, and mood issues).Resident #6's physician's order's, dated 7/1/25, documented for Lyrica (an anticonvulsant drug used to treat neuropathic pain and fibromyalgia) 150 mg in the morning and Lyrica 200 mg at bedtime related to fibromyalgia.a. The facility's Medication Error Report, dated 10/21/25, documented a medication error occurred on 10/20/25 in the morning when the nurse administered the bedtime dose of Lyrica 200 mg to Resident #6 instead of the ordered of Lyrica 150 mg.b. The facility's Medication Error Report, dated 10/25/25, documented a medication error occurred on 10/24/25 at bedtime when the nurse administered the morning dose of Lyrica 150 mg to Resident #6 instead of the ordered 200 mg of Lyrica.c. The facility's Medication Error Report, dated 10/27/25, documented a medication error occurred on 10/27/25 when the day nurse failed to administer the morning dose of Lyrica 150 mg to Resident #6.On 11/7/25 at 12:47 AM, the DON confirmed on 10/20, 10/24, and 10/27, medication errors occurred involving Resident #6's Lyrica.4. Resident #7 was admitted to the facility on [DATE] with multiple diagnoses including osteomyelitis (a bacterial infection of the bone), diabetes, and kidney failure.Resident #7's physician's orders, dated 10/9/25, documented, daptomycin (an antibiotic) intravenous solution reconstituted, 1250 mg intravenously in the morning every other day for infection related to osteomyelitis.The facility's Medication Error Report documented a medication error occurred on 10/19/25 when nurse administered ceftriaxone (an antibiotic) 1 gm intravenously instead of the ordered daptomycin. On 11/7/25 at 12:54 PM, the DON confirmed the nurse administered Resident #7 the wrong IV antibiotic on |