STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karcher Post Acute	1127 Caldwell Boulevard Nampa, ID 83651

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on interviews of residents, resident representatives, and staff, and record review, it was determined the facility failed to ensure a resident's cultural/religious rights were honored. This was true for 1 of 1 resident (Resident #28) whose record was reviewed for resident rights. This failure resulted in psychosocial harm to Resident #28 when a certified nursing assistant (CNA) cut her hair without her consent. Findings include: Resident #28 was admitted to the facility on [DATE], for care following a stroke and had multiple diagnoses including chronic kidney disease and dementia. A facility incident report, dated 2/12/25, documented staff were pulling Resident #28's hair while brushing it, then cut her hair. The report documented CNA #1 stated Resident #28 was uncooperative with staff attempting to brush the knots out of her hair, and CNA #1 cut about an inch or inch and a half from Resident #28's hair. The report did not specify if Resident #28 was asked for her consent before CNA #1 cut her hair. On 4/3/25 at 5:00 PM, Resident #28 and her representative were interviewed together. Resident #28 stated, I don't cut my hair, my hair came from Jesus. She became upset and stated, If I cut my hair, I'll go to hell. Resident #28's representative stated Resident #28 chooses not to cut her hair for religious reasons, and she informed the facility of this on the day of Resident #28's admission. The representative stated Resident #28 was upset about her hair being cut when the representative visited her afterward. She stated she brought it to the administrator's attention that someone had cut Resident #28's hair without her consent. Resident #28's care plan, dated 11/24/24, documented she required assistance to complete her daily hygiene tasks, such as bathing and caring for her hair. The care plan did not document her preference to wear her hair long or her religious beliefs that her hair should never be cut. On 4/3/25 at 5:45 PM, the Administrator stated he was aware Resident #28 had religious beliefs and she chose not to cut her hair. He added CNA #1 was trying to be helpful by cutting the knots out of Resident #28's hair rather than upset her while brushing them out, and CNA #1 did not know Resident #28 did not cut her hair for religious reasons.

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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	135110	A. Building B. Wing	04/04/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review, review of the State Survey Agency's Long-Term Care Reporting Portal, and resident and staff interview, it was determined the facility failed to report alleged verbal abuse to the State Survey Agency within 5 days. This was true for 1 of 6 residents (Resident #11) reviewed for abuse. This failure created the potential for residents to be subjected to ongoing abuse without detection and protective measures implemented by the facility. Findings include: Resident #11 was initially admitted to the facility on [DATE], with multiple diagnoses including diabetes and morbid obesity. Resident #11's Admission MDS assessment, dated 9/15/24, documented Resident #6 was cognitively intact. The Grievance Logs from October 2024 to April 2025 were reviewed. A grievance, dated 10/18/24, documented Resident #11 felt publicly shamed by the dietitian in front of other residents when the dietitian asked about her ordering habits such as chicken fried steak and other high-calorie items. When Resident #11 responded about the weight she had lost, the dietitian commented Resident #11 would have lost more weight if she had stuck to the diet plan. A review of the State Survey Agency's Long-Term Care Reporting Portal documented the alleged verbal abuse was uploaded on 4/1/25, approximately six months after the alleged incident. On 4/2/25 at 3:04 PM, the DON stated, I wasn't here last October [2024], as I was hired at the end of December [2024]. The Administrator and I reviewed the grievances on 4/1/25, recognizing this grievance was not reported to the State Portal as it should have been. We [the Administrator and the DON] immediately uploaded the incident to the State Reporting Portal, and started an investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review, review of facility Grievance Logs, and staff interview, it was determined the facility failed to ensure allegations of verbal abuse were thoroughly investigated for 1 of 6 residents (Resident #11) reviewed for abuse. This failure created the potential for Resident #11 to be subjected to ongoing abuse without detection and intervention. Findings include: Resident #11 was initially admitted to the facility on [DATE], with multiple diagnoses including diabetes and morbid obesity. Resident #11's Admission MDS assessment, dated 9/15/24, documented Resident #11 was cognitively intact. A review of Grievance Logs from October 2024 to April 2025, included a grievance, dated 10/18/24. The grievance documented Resident #11 was publicly shamed by the dietitian in the lobby area while other residents were present. The dietitian asked Resident #11 about her ordering habits such as chicken fried steak and other high-calorie items. When Resident #11 responded about the weight she had lost, the dietitian commented Resident #11 would have lost more weight if she had stuck to the diet plan. The report did not include what was done to protect the resident from further verbal abuse; staff and resident interviews; or the facility's conclusion of the investigation. A review of the State Survey Agency's Long-Term Care Reporting Portal documented the 10/18/24 incident was uploaded on 4/1/25, approximately six months after the incident. On 4/2/25 at 3:04 PM, the DON stated, I wasn't here last October [2024], as I was hired at the end of December [2024]. The Administrator and I reviewed the grievances on 4/1/25 recognizing this grievance was not reported to the State Portal as it should have been. We [the Administrator and the DON] immediately uploaded the incident to the Portal and started an investigation. On 4/4/25 at 11:45 AM, the DON stated the investigation had been completed and it was found there was not enough evidence to substantiate allegations of mistreatment or verbal abuse. The DON stated the investigation was uploaded it to the State Reporting Portal on 4/4/25. A review of the State Survey Agency's Long-Term Care Reporting Portal documented a final investigation report, dated 4/4/25.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review and staff interview, it was determined the facility failed to ensure residents' MDS documented correct assessment information. This was true for 2 of 14 residents (#16 and #30) whose records were reviewed for accuracy. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: The Resident Assessment Instrument (RAI), revised 10/1/24, documented if a PASARR (Preadmission Screening and Resident Review) level II determined a resident has a serious mental illness, then section A1500 of the MDS should be marked yes. 1. Resident #16 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels, oscillating between periods of mania and depression, significantly impacting daily functioning). Resident #16's medical record documented a PASARR level II, dated 7/3/23, was completed. Resident #16's MDS assessment, dated 9/18/24, and quarterly MDS review, dated 12/10/24, documented, no at A1500. 2. Resident #30 was admitted on [DATE], with multiple diagnoses including dementia, anxiety, and depression. Resident #30's medical record documented a PASARR level II was completed on 2/12/25. Resident #30's admission MDS assessment, dated 2/12/25, documented no at A1500. On 4/3/25 at 3:30 PM, the MDS Coordinator stated any PASARR level II not requiring additional services will have no selected at A1500. The MDS Coordinator was not aware a PASARR level II on file would need to be marked yes at A1500. She stated both Resident #16 and Resident #30 did have a PASARR level II on file and the MDS should have been marked yes at A1500.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on interviews of residents, resident representatives, and staff, and record review, it was determined the facility failed to ensure a resident's cultural/religious preferences were included in their care plan. This was true for 1 of 14 residents (Resident #28) whose care plans were reviewed. This failure placed Resident #28 at risk for their religious rights not being honored. Findings include: Resident #28 was admitted to the facility on [DATE] for care following a stroke, and had multiple diagnoses including chronic kidney disease and dementia. On 4/3/25 at 5:00 PM, Resident #28 stated, I don't cut my hair, my hair came from Jesus. Resident #28's representative added Resident #28 chooses not to cut her hair for religious reasons and she informed the facility of this on the day of her admission. Resident #28's care plan, dated 11/24/24, documented she required assistance to complete her daily hygiene tasks, such as bathing and caring for her hair. Resident #28's care plan did not document her preference to wear her hair long or her religious beliefs that her hair should never be cut. On 4/3/25 at 5:45 PM, the Administrator stated he was aware Resident #28 had religious beliefs and she chose not to cut her hair but did not know why her religious beliefs were not included in her care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents and their representatives were provided the opportunity to participate in care planning and attend care conferences. This was true for 1 of 14 residents (Resident #27) whose care plans were reviewed. This placed resident #27 at risk for adverse outcomes if care and services were not provided due to care plans not being reviewed and revised as the resident's needs changed. Findings include. The Facility's Care Conference policy, dated February 2019, documented, Care conferences will be scheduled with the resident and/or resident representative to review care plan goals and interventions. Care Conferences will be held upon admission, quarterly and with any significant change in conjunction with MDS Assessment. Review of the care plan with the resident and/or resident representative shall be documented in the EHR [Electronic Health Record]. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including renal (kidney) disease, high blood pressure, dementia, depression, and respiratory failure. On 4/1/25 at 11:33 AM, Resident #27's representative stated she had not been contacted regarding any care conferences since last summer [2024]. Resident #27's care plan, dated 2/21/21, instructed the facility to conduct quarterly care conferences and as needed for Resident #27. A review of Resident #27's medical record from August 2024 through January 2025, did not include documentation of care conferences with Resident #27 and/or her representative. On 4/2/25 at 4:29 PM, the DON stated care conferences were being completed and placed in the nursing progress notes, but they were documented incorrectly so there is no record of who attended the conference and what was discussed. The DON confirmed Resident #27's record did not include documentation of care conferences being performed.

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	135110	A. Building B. Wing	04/04/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40733 Based on reviews of incident reports and medical records, and staff interviews, it was determined the facility failed to implement interventions to reduce residents' risk of accidents. This was true for 1 of 4 residents (Resident #20) reviewed for accidents. This failure resulted in Resident #20 experiencing a fall when her soft touch call light was not available for use. Findings include: Resident #20 was admitted on [DATE], with multiple diagnoses including dementia, Alzheimer's disease, and encounter for palliative care. A facility accident report, dated 1/17/25, documented facility staff found Resident #20 on her right side, on the floor next to her bed. She was assessed by a nurse and no injuries were found. The report concluded that Resident #20 attempted to transfer herself without assistance, and the facility implemented [the] use of [a] soft pad call light as [an] intervention to prevent falls in [the] future. A care plan intervention, revised on 1/22/25, instructed staff to keep a soft touch call light within Resident #20's reach and to keep Resident #20 within supervised view as much as possible. A facility accident report, dated 3/3/25, documented Resident #20 had an unwitnessed fall when she attempted to transfer herself in her room and fell next to her bed. Resident #20 was unable to explain what had happened. She was assessed by a nurse with no injuries found. The report concluded that Resident #20 did not activate her call light before the fall. A late entry note, dated 3/6/25, documented the facility changed Resident #20's call light out for a larger soft touch type of call light button. In an interview on 4/3/25 at 4:06 PM, the DON stated Resident #20 changed rooms around the end of February and her soft touch light was not moved with her. The DON stated the oversight was discovered when Resident #20 fell again in March and the soft touch call light was installed and reeducation was provided to staff.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48401 Based on record review and staff interview, it was determined the facility failed to ensure a resident was free from duplicate pain medication therapy without clear parameters for administration. This was true for 1 of 6 residents (Resident #9) whose records were reviewed for unnecessary medications. This failure created the potential for harm and adverse effects if Resident #9 was to receive inappropriate opioid medication. Findings include: Resident #9 was readmitted to the facility on [DATE] with multiple diagnoses including dementia, fibromyalgia, and chronic pain syndrome. Resident #9's electronic health record (HER) documented the following medications ordered by her physician on 3/24/25: -acetaminophen (an analgesic) oral tablet 500 mg, give 1 tablet by mouth, every 6 hours, as needed for pain -hydrocodone-acetaminophen (an opioid analgesic) oral tablet 5-325 mg, give 1 tablet by mouth, every 6 hours, as needed for hip pain related to chronic pain syndrome -Tramadol (an opioid) HCL oral tablet 50 mg, give 1 tablet by mouth, every 8 hours, as needed for pain A note from the consulting pharmacist to the physician documented a recommendation to update Resident #9's hydrocodone and Tramadol orders with clear instructions using the pain scale to determine the appropriate medication to give. This note was signed by the physician on 3/24/25 with the response, no changes. On 4/4/25 at 1:02 PM, the DON stated the acetaminophen, hydrocodone, and Tramadol orders for Resident #9 were not clear and needed to be updated with more specific instructions for their use.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50603 Based on record review, review of facility's policy and procedure, review of Incidents and Accidents reports, and staff interview, it was determined the facility failed to ensure residents were free from significant medication errors. This was true for 2 of 2 residents (#11 and #16) reviewed for medication errors. Findings include: The facility's Medication Administration policy, dated January 2023, documented: Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the resident's MAR with the medication label. Verify medication is correct three times before administering the medication: 1. When pulling medication packages from the medication cart, 2. When dose is prepared, and 3. Before dose is administered. Residents are identified before medication is administered using at least two resident identifiers: 1. Check identification band, 2. Check photograph attached to medical record, and/or 3. Verify resident identification with other nursing care center personnel. The facility's Medication Administration - Errors policy and procedure, dated February 2019, directed staff to: 1. Report a medication error in the risk management systems. 2. Notify the physician and resident/resident representative of the medication error. 3. Place resident on alert monitoring for adverse effects. 4. The [DON] will be responsible to ensure an investigation is completed, identifying cause of error and need for system review, etc. 5. The [DON] should implement counseling and/or corrective action as needed. 6. Errors resulting in negative outcome, potential for serious negative outcome and those as a result of failure to comply with nursing standards, will be reported to the appropriate State Agencies and Licensing Boards. 1. Resident #11 was initially admitted to the facility on [DATE], with multiple diagnoses including a left leg fracture, chronic migraine, and non-pressure chronic ulcer. A physician's order, dated 10/25/24, documented Resident #11 was to receive Oxycodone (narcotic pain medication), 5 mg every 3 hours for chronic pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An I&A report, dated 11/5/24, documented Resident #11 had received 10 mg of Oxycodone instead of the ordered 5 mg on 11/4/24. The 10 mg was supposed to be given to her roommate. The facility notified the doctor. Resident #11 was monitored for adverse effects and the evening dose was withheld. The facility identified Resident #11 and her roommate had same medication (Oxycodone) ordered in different strengths. The nurse had pulled the same medication out for both residents and gave the incorrect medication dose to Resident #11. The nurse was educated on the 10 rights of Medication Administration on 11/6/24. On 4/3/25 at 3:23 PM, the DON stated Resident #11 had received her roommate's dose of 10 mg of Oxycodone as the nurse had chosen to administer both roommates their medication at the same time. She stated the nurse was educated on providing one resident's medication at a time to avoid future errors. The DON stated the nurse should have given the medication individually. 2. Resident #16 was admitted to the facility on [DATE], and readmitted on [DATE], with the diagnosis of diabetes. A physician's order, dated 8/30/24, documented Resident #16 was to receive Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-injector 100 UNIT/ML: Inject as per sliding scale: if 0 - 70 = 0 units and notify provider; 71 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units and notify provider, subcutaneously before meals. A physician's order, dated 9/25/24, documented Resident #16 was to receive Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine): Inject 30 units subcutaneously two times a day. An I&A report, dated 11/13/24, documented Resident #16 received the incorrect insulin. The nurse was distracted answering questions from family members and gave the incorrect medication to Resident #16. The physician and Resident #16 were notified of the medication error. Resident #16 was placed on alert charting with blood sugars being checked within 30 minutes and then again in two hours. Resident #16 did not have signs or symptoms of hypoglycemia (low blood sugar). On 4/3/25 at 4:15 PM, the DON stated, The nurse was distracted and gave Resident #16 a fast-acting insulin versus the slow-acting insulin. She followed our Medication Error policy when she alerted the doctor and resident, also placing the resident on alert charting. All nursing staff were educated after this incident; however, I cannot find the staff sign-in sheet as this was done under old administration and I did not start until the end of December 2024. Documentation of the completed staff training was requested and not provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50603 Based on observation, resident interview, test tray evaluation, and staff interview, it was determined the facility failed to ensure food was served at an appropriate temperature. This affected 1 of 4 residents (Resident #40) who were reviewed for dietary concerns. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: On 3/31/25 at 3:11 PM, Resident #40 stated, I eat my meals in my room. The food is not warm when I get it. On 4/3/25 at 12:55 PM, a lunch meal test tray was evaluated by three surveyors and the Registered Dietitian. The main dish of taco salad (lettuce, ground beef, kidney beans, cheese) had an internal temperature of 85-degrees Fahrenheit. The side of cooked beans had an internal temperature of 113-degrees Fahrenheit. The yogurt had an internal temperature of 52-degrees Fahrenheit, and the custard dessert had an internal temperature of 57-degrees Fahrenheit. The dietitian confirmed the food had been placed incorrectly in the food cart where the cold side of the tray was placed on the warming side, and the hot side of the tray was placed on the cold side of the food cart. On 4/4/25 at 9:56 AM, the Kitchen Manager stated the dining cart is usually not turned on so the food will remain at the temperature it was plated. She acknowledged the staff had placed the food tray into the cart incorrectly (hot on cold side/cold on hot side), and the temperature of the food would be affected from the time of plating until a resident received it.

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	135110	A. Building B. Wing	04/04/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50603 Based on observation, Food Drug Administration (FDA) Food Code, and staff interview, it was determined the facility failed to ensure kitchen equipment was maintained, cleaned, and sanitized. These deficiencies had the potential to affect the 54 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes due to contaminated food services equipment. Findings include: 1. FDA Food Code Section 4-602.11 Equipment Food-Contact Surfaces and Utensils documented: (E) Surfaces of utensils and equipment contacting food that is not time/temperature control for food shall be cleaned: (4) (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. On 3/31/25 at 8:30 AM, and 4/4/25 at 9:56 AM, a layer of dark brown dust was observed coating the pan drying rack, and a darker brown coating of dirt was observed in the corner of the walk-in freezer. On 4/4/25 at 10:10 AM, the Dietary Manager (DM) stated the pan drying rack was dusty and should have been cleaned. She also stated the freezer is cleaned by a third-party source and she did not know when it was last cleaned, but the freezer should have been cleaned. 2. The FDA Code Section 4-602.12 Cooking and Baking Equipment documented: Food-contact surfaces of cooking equipment must be cleaned to prevent encrustations that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use. On 3/31/25 at 8:30 AM, and 4/4/25 at 9:56 AM, three aluminum skillets were observed to have a thick layer of black coating on the interior and exterior which the DM was able to scrape off with her fingernail. On 4/4/25 at 9:56 AM, the DM stated the skillets were aluminum and should not have a coating of black residue on them. 3. The FDA Food Code Section 6-501.12 Cleaning, Frequency and Restrictions, documented cleaning of the physical facilities is an important measure in ensuring the protection and sanitary preparation of food. A regular cleaning schedule should be established and followed to maintain the facility in a clean and sanitary manner. Primary cleaning should be done at times when foods are in protected storage and when food is not being served or prepared. On 3/31/25 at 8:30 AM, and 4/4/25 at 9:56 AM, a thick layer of ice build-up walk-in was observed on the pipe going from the walk-in refrigerator into the freezer. A large sheet of ice was observed coating a stack of three opened cardboard boxes of pizza dough. On 4/4/25 at 10:17 AM, the DM stated ice should not be coating the food boxes, the pipes, or dripping from the air condenser unit. She stated a third-party company cleans the walk-in refrigerator and freezer as the units would need to be shut down. The DM did not know when it had last been cleaned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karcher Post Acute	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/25 at 1:40 PM, the Administrator stated the walk-in refrigerator and freezer should be cleaned whenever it is dirty. He stated either maintenance or the kitchen staff should be keeping it clean. The Administrator stated the outside vendor only handles the equipment maintenance, not the cleaning.