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	07/02/2024

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 0622 Level of Harm - Actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48654 Based on policy review, record review, review of the State Agency's Long Term Care Reporting Portal, and resident and staff interview, it was determined the facility failed to ensure a resident's right to stay in the facility and the right to appeal the decision for a facility-initiated discharge. This was true for 1 of 3 residents (Resident #1) reviewed for facility-initiated discharges. This deficient practice caused Resident #1 to experience psychosocial harm when he was discharged to a motel without the ability to check his blood sugar and safely administer insulin. Findings include: The facility's Notice of Transfer or Discharge policy, dated 4/2020, documented the notice of transfer/discharge shall be made 30 days prior to transfer/discharge unless the health and/or safety of the resident or residents residing in this center are endangered. Appendix PP, State Operations Manual, states there may be rare situations, such as when a serious crime (e. g., attempted murder or rape) has occurred, that a facility initiates a discharge immediately, with no expectation of the resident's return. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including Type 2 Diabetes Mellitus, Long term (current) use of Insulin, Depression, and Legal Blindness. Resident #1's care plan, initiated on 2/1/24, documented he had impaired visual function and was at risk for falls related to his visual impairment, legal blindness. Resident #1 care plan, initiated 2/2/24, documented that Resident #1 wished to remain in the facility. An admission MDS assessment, dated 2/2/24, documented Resident #1 was cognitively intact, vision was highly impaired, and physical and verbal behavioral symptoms directed towards others were not exhibited. A quarterly MDS assessment, dated 5/2/24, documented Resident #1 was cognitively intact, had adequate vision, able to see fine detail including regular print in newspapers/books, and physical and verbal behavioral symptoms directed towards others were not exhibited. (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 0622 Level of Harm - Actual harm Residents Affected - Few	The State Agency's Long Term Care Reporting Portal included a facility initial report, dated 6/25/24 at 1:15 PM, which documented an incident between Resident #1 and Resident #2. The report documented, LTC Residents, [Resident #1], [Resident #3], and [Resident #2] were outside in the designated smoking area. All Residents are alert and oriented x4. [Resident #1] and [Resident #3] are consented boyfriend and girlfriend. They were sitting on the bench outside and kissed. Based on statements from the residents, [Resident #2] yelled at [Resident #1] and [Resident #3] and said, 'get a room!' [Resident #1] responded by picking up the garden hose (used to water the flowers nearby) and sprayed [Resident #2] with water. [Resident #2] stated she is okay but not happy. [Resident #1] said, 'for what [Resident #2] said, that is the appropriate thing to do.' Residents were separated at this time. No injuries reported. Investigation started. The State Agency's Long Term Care Reporting Portal also included documentation of an immediate action plan, dated the same day and time as the initial report. The immediate action included notification for local police to talk with Resident #1 about using the garden hose to spray water on another resident, Resident #1 and Resident #2 were separated, and both residents stated they felt safe. A progress note, dated 6/25/24 at 2:04 PM, documented after the incident Resident #1 was placed on 1:1 supervision and was being closely monitored by facility staff. The note further documented Resident #1's provider gave approval to send him to the hospital for evaluation. A progress note, dated 6/25/24 at 9:35 PM, documented Resident #1 returned from the hospital after evaluation at approximately 9:15 PM via a non-medical ambulatory transport service and had no signs or symptoms of distress. The note documented Resident #1 was cooperative with the nurse and his cares. A progress note, dated 6/26/24 at 5:58 AM, documented Resident #1 slept through the night and remained in his room, with no problems. A progress note, dated 6/26/24 at 2:26 PM, documented Resident #1 stayed in his room throughout the day shift. He was assigned a 1:1 CNA to monitor him for safety reasons and no further episodes of this type of behavior was noted on that shift. A progress note, titled late entry, dated 6/26/24 at 9:15 PM, documented Resident #1 was in the DON's office with the Administrator and Social Services where options for discharge were discussed. Resident #1 was given three options including a hotel, with the power of attorney, or the homeless shelter. It also stated nursing staff would provide him with his medication list in large print due to difficulty with his eyesight. Medication organizers were also provided with labels in large print. A progress note, titled late entry, dated 6/26/24 at 9:16 PM, documented Resident #1 was able to give a return demonstration for administering his insulin on his own. A Social Services progress note, titled late entry, dated 6/26/24 at 5:49 PM, documented the DON, Administrator and Social Services Director spoke with Resident #1 on discharge options after he was given a discharge notice due to behaviors and threatening comments towards staff and residents. Resident #1 chose to be sent to a hotel paid by the facility. The Social Services Director made a three-night reservation at a local motel. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 6/26/24 at 6:31 PM, documented Resident #1 was discharged and was not allowed in the facility. The note documented if he came to the facility, to CALL THE POLICE IMMEDIATELY. This is trespassing and he will be arrested. The message was relayed by the DON. There was no documentation in Resident #1's record the facility discussed with Resident #1 he could remain in the facility for 30 days as stated on the discharge notice. Resident #1's record also did not include documentation the facility discussed with Resident #1 he had the right to appeal the facility-initiated discharge. On 7/1/24 at 11:20 AM, Resident #4 stated Resident #1 was his roommate and he heard that Resident #1 was kicked out because he sprayed a hose at a resident. He stated that he never had a problem with Resident #1, he was a nice guy. He also stated that he has never seen Resident #1 hit or strike out at another resident. During an interview with the surveyors at Resident #1's hotel on 7/1/24 at 12:30 PM, Resident #1 stated that he and Resident #3 were out by the smoking area kissing. He stated Resident #2 came outside and said, you guys are disgusting and that was when he sprayed Resident #2 with the hose. He stated, the day they kicked me out was the worst day of my life, worse than the day I lost my sight. I just want to die after what they did to me. Resident #1 did state to the surveyors he was not suicidal and could not kill himself. When asked, he stated he would go back to the facility if he could, I have nowhere to go. Resident #1 stated he did not receive a discharge notice. He was told the next day that he had to leave, they packed up my stuff, gave me my medications, and no way to check my blood sugar. When the surveyor asked if he was taking his insulin, Resident #1 stated just my Lantus (long-acting insulin), 25 units in the morning. He stated he could not take his Humalog (short-acting insulin) because he was not provided a way to check his blood sugar. When asked how he adjusted the insulin pen, Resident #1 stated I count the clicks because I can't see the numbers. Resident #1 allowed the surveyor to review the documentation that was provided to him at discharge. After review, the surveyor noted that the 30-day discharge notice was present in the documentation. When asked if he was able to read the notice, he stated no, the words are too small. The discharge notice was in small, newspaper style print. Resident #1 allowed the surveyor to visualize his insulin pen and it was observed to be set at 24 units, not 25 units as prescribed. During the interview with Resident #1, the surveyor observed he was emotionally distressed as evidenced by tearful moments throughout the interview. On 7/1/24 at 3:15 PM, Resident #3 stated she remembered the incident between Resident #1 and Resident #2. She stated she was outside on the bench smoking and visiting with Resident #1 when Resident #2 came out and starting yelling at them to get a room when she saw them kissing. Resident #3 stated she yelled back pay for it then Resident #2 went over to them in her wheelchair and kept screaming at them. Resident #3 stated I'm pissed he was kicked out and nothing happened with her. (continued on next page)

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F 0622 Level of Harm - Actual harm Residents Affected - Few	On 7/1/24 at 3:20 PM, Resident #2 stated she did not have issues with other residents anymore, now that Resident #1 was kicked out. [Resident #1] had a bad temper, and he took what I said seriously. I told them to get a room and he started calling me names and sprayed me with the garden hose. When asked how long Resident #1 sprayed her with the hose, Resident #2 stated not for long. On 7/1/24 at 4:11 PM, RN #1 stated she had not witnessed any other incidents between Resident #1 and Resident #2. RN #1 also stated she had not witnessed Resident #1 in any other physical interactions with other residents and had not witnessed him throwing anything or threatening other residents. On 7/2/24 at 10:52 AM, the Regional Ombudsman stated she was aware of the situation and had a conversation with the Social Services Director about Resident #1. She stated she made them aware if he was a safety concern then they could discharge him. She also stated she was not made aware of his diagnoses of legal blindness or that he was insulin dependent. On 7/2/24 at 1:43 PM, CNA #1 stated she provided cares to Resident #1, and he never yelled at or become aggressive with her. On 7/2/24 at 1:50 PM, CNA #2 stated she never saw or witnessed Resident #1 yelling or acting out. She stated she had not witnessed negative interactions involving Resident #1. On 7/2/24 at 2:30 PM, LPN #1 stated she had provided cares for Resident #1, and he could be hard to redirect. She also stated she had not witnessed Resident #1 physically put his hands on anyone in anger. She stated that he will get in people's faces. On 7/2/24 at 3:05 PM, the Social Services Director stated she was not in the facility on 6/25/24, the day of the incident. She was informed of the incident the next day and was instructed to begin finding placement for Resident #1. She stated Resident #1 became angry when he was given the 30-day notice of discharge and 3 options to go to after discharge. She stated the options given to Resident #1 were the motel, homeless shelter, or his friend's house. She stated he chose the motel as his option. On 7/2/24 at 6:02 PM, the Administrator stated due to Resident #1's behavior and statements, he felt they did the right thing. He also stated if Resident #1 had not accepted the hotel option, he would have kept Resident #1 in the facility.