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	11/07/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 (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

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	11/07/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, however, she refused.The incident report included a staff statement, taken by the DON from CNA #12, dated 7/12/25, documenting, I went in and asked [Resident #50] if she wanted to get up right before lunch and she stated no, so I went and told [CNA #17] then went [to assist another resident].The incident report included a staff statement, dated 7/12/25, CNA #17 documented, I worked on 7/12/25 with another aide, [Resident #50] expressing pain and not wanting to get up. [LPN #20] who was the nurse that shift gave some meds and [Resident #50] was still expressing pain, refusing cares, and to get up. Neither myself or [the other aide] had provided any cares to her on this shift as we attempted but she continued to refuse and would not allow us to get her up or change her. [RNA #1] was hoping to get [Resident #50] up but [CNA #8] stated that we were not to force her to do anything.The incident report included a staff statement, dated 7/17/25, CNA #9 documented, Before [Resident #50] went to the hospital, I was in the room with [CNA #8 and RNA #1]. [CNA #8] didn't want to get [Resident #50] up because she looked really tired, but [RNA #1] wanted to get her up. [Resident #50] was yelling for her mom and CNA #8 was trying to calm her down. I left the room while they were getting ready.The incident report included a staff statement, dated 7/12/25, LPN #20 documented, [Resident #50] was not wanting to get out of bed this morning, when asked why she would mumble and close her eyes. [Resident #50] did take her medication and I told her she could stay in bed. I communicated to [the CNA's] that it was okay to leave her in bed since that is what [she] wanted. [Restorative Nurse Aide (RNA) #1] was requesting [Resident #50] be up for exercise, I reaffirmed to leave her in bed.The incident report included a staff statement, dated 7/12/25, CNA #8 documented, Numerous times for the morning of my work shift, I asked what we should do if [Resident #1] refused care and stated to leave her alone and reapproach her at another time. We attempted 5 to 6 times. CNA #8's statement continued, [LPN #10] asked us [CNA #8 and RNA #1] to go get her up and get her changed as she was wet. [RNA #1] helped pull her up from a laying position to a sitting position and [Resident #50] got a bit combative, but this is normal for [her] as she gets very scared. The statement continued, she shortly after sat in her chair and her head (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	11/07/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	shot up crooked towards the ceiling and she began to start blinking rapidly and trying to respond. I said that I was getting the nurse and that something was not right. I ran to get the nurse.The incident report included the records from Resident #50's hospitalization. The emergency department physician documented patient with history of advanced dementia, comes from skilled nursing facility with possible convulsions.The hospital records documented a diagnosis of displaced left femoral neck fracture (break in the bone that connects the hip to the thigh where the fractured segment is moved out of position).The hospital records documented a reported episode of possible convulsion and no corroborating evidence of seizure event following computed tomography (CT) scan (a medical imaging procedure that uses X-rays and computer technology to create detailed, cross-sectional images of the inside of the body) of her head with no acute findings.On 11/7/25 at 1:13 PM, CNA #8 stated he provided a written statement to the facility of his observation during the incident on 7/12/25 with Resident #50. CNA #8 stated the DON said his statement was unacceptable and shredded his original statement. CNA #8 reported, the DON typed up a second statement minimizing the severity of the situation and made him sign it, and the second statement is the one in the investigation report. CNA #8 provided a copy of his original statement dated 7/12/25. The original statement documented Numerous times for the morning of my work shift I was asked what the staff were supposed to do if [Resident #50] refused care. I stated we are to leave her alone and reapproach at another time. While the day went on, this resident had refused about 5-6 different times, when lunch was approaching around noonish- [LPN #10] stated it was neglect and abuse to leave her [soiled] so [RNA #1] and I were going to try to reapproach her. When we got to her room, the resident was already requesting to be left alone when [RNA #1] pulled her up from a laying position to sitting. When [RNA #1] did that, [Resident #50] started to fight against [RNA #1] and was swinging at her. I asked if I could help and maybe change her just in bed and [RNA #1] said she was wet and had to get up. [RNA #1] was focused on getting her out of bed and she did not put shoes on [Resident #50]. When she sat her in the wheelchair, her head shot up, crooked toward the ceiling and she began to stutter and blink rapidly, still trying to respond. I said, I'm going to get the nurse, something isn't right.On 11/7/25, at 1:25 PM, CNA #8 stated, Resident #50 had been approached multiple times that morning and continuously refused to get out of bed and LPN #20 had directed him to let her rest. CNA #8 stated RNA #1 was trying to get her out of bed for restorative activities and he reminded her of their training the month prior, that Resident #50 should not be transferred if she is refusing or combative to avoid injury. CNA #8 stated he observed RNA #1 picking up Resident #50 under her arms, without footwear on, while she was yelling and striking RNA #1. CNA #8 reported he was shocked RNA #1 was picking up the resident, and brought the wheelchair closer to try to keep her safe. CNA #8 stated, RNA #1 firmly placed Resident #50 into her wheelchair and he heard two snapping or cracking sounds. He stated, Resident #50 immediately threw her head back and began making full body jerking movements and yelling ow, 911 repeatedly through a garbled voice.On 11/7/25 at 1:48 PM, LPN #20 stated, I instructed the CNAs to leave [Resident #50] in bed if she wanted to rest, and [RNA #1] did not listen.On 11/7/25 at 3:14 PM, the DON stated the 2 CNAs involved did not report Resident #50 was transferred unsafely. The DON was asked, did the CNA's follow the care plan for transferring?, she responded, yes, because [Resident #50] would always refuse and become combative no matter what you were approaching her with.On 11/7/25 at 3:44 PM, the Administrator stated he was not employed at the facility at the time of the incident. He added, it seemed like they were in a tough spot and there is a fine line between neglecting someone by leaving them soiled or abusing them by transferring them when they're refusing.

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	11/07/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **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 (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	11/07/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 10/19/25. 5. Resident #8 was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including cerebral palsy (CP is caused by abnormal brain development or damage to the developing brain that affects a person's ability to control their muscles) and dysphasia (inability to use or understand language).Resident #8's physician's orders, dated 8/21/25, documented to give an enteral feed four times a day for nutritional needs, Vital AF 1.2 calorie nutrition formula - 250 ml, bolus feeds (a method of delivering nutrition directly into the stomach through a gastrostomy (G-tube) feeding tube using a large syringe and gravity. The bolus method involves infusing a set amount of formula, similar to a single meal, over a short period of time).The facility's Medication Error Report documented a medication error occurred on 10/13/25 when Resident #8 was not administered his enteral feeding as ordered.On 11/7/25 at 12:56 PM, the DON confirmed Resident #8 was not administered his ordered tube feeding on the evening of 10/13/25 in error. 6. Resident #9 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD is a disease that causes airflow blockage and breathing related problems), diabetes, and opioid dependence.Resident #9's physician's order, dated 7/9/25, documented fentanyl transdermal patch 25 mcg/hour, apply one patch every 3 days for pain. The facility's Medication Error Report documented a medication error occurred on 9/10/25 when Resident #9 was administered Fentanyl 37.5 mcg/hour transdermal patch. The mistake was reported on the evening of 9/11/25 when it was noted the narcotic count was not correct.On 11/7/25 at 1:00 PM the DON confirmed Resident #9 was administered the wrong dose of Fentanyl on 9/10/25 and it was not discovered until 9/11/25. 7. Resident #10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including stroke and insomnia (a sleep disorder characterized by persistent difficulty falling or staying asleep).Resident #10's physician's order dated 7/18/25, was for zolpidem tartrate (Ambien) 10 mg, give 1 tablet by mouth at bedtime for insomnia.The facility's Medication Error Report documented a medication error occurred on 8/7/25 when Resident #10 was administered 20 mg of Ambien rather than the 10 mg ordered.On 11/7/25 at 1:02 PM the DON confirmed Resident #10 was administered double the ordered dose of Ambien on 8/7/25. 8. Resident #11 was admitted to the facility on [DATE] with multiple diagnoses including respiratory failure, heart failure, and end of life care.Resident #11's physician's order, dated 7/18/25, documented an order for alprazolam (Xanax) 1 mg tablet, give 1 mg by mouth at bedtime for anxiety.Resident #11's physicians orders did not include an order for tramadol 50mg.The facility's Medication Error Report documented a medication error occurred on 7/22/25 when Resident #11 was administered another resident's tramadol 50 mg instead of the ordered Xanax.On 11/7/25 at 1:05 PM, the DON confirmed Resident #11 was administered another resident's tramadol by mistake.