



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

July 24, 2015

Richard Strong, Administrator
Meridian Center Genesis Healthcare
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Strong:

On **July 17, 2015**, a Facility Fire Safety and Construction survey was conducted at **Meridian Center Genesis Healthcare** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator

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should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 6, 2015**. Failure to submit an acceptable PoC by **August 6, 2015**, may result in the imposition of civil monetary penalties by **August 26, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 14, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 14, 2015**. A change in the seriousness of the deficiencies on **August 14, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 14, 2015**, includes the following:

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Denial of payment for new admissions effective **October 17, 2015**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 17, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 17, 2015**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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Go to the middle of the page to Information Letters section and click on State and select the following:

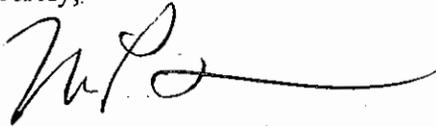
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 6, 2015**. If your request for informal dispute resolution is received after **August 6, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

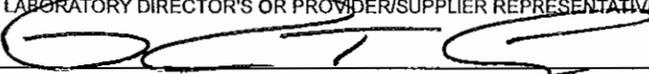
Printed: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2015
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NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The facility is a single story Type V (III) construction completed in March 1997. The facility is fully sprinklered and has a complete fire alarm system with smoke detectors throughout. There is an upper level of the facility and is only used for classrooms, medical records, marketing and board room. The facility is currently licensed for 139 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on July 16, 2015 - July 17, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	<p style="text-align: right;">RECEIVED AUG 20 2015 SAC, IDHHS/CLIA</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Meridian Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This Standard is not met as evidenced by:	K 025	<p>K025 Identified: Unsealed 1" Circular hole near Health Information office was sealed by Director of Maintenance with Fire Seal on 07/20/2015.</p> <p>Audits: Facility Wide: All smoke barrier walls were inspected on or before 08/06/2015 by Director of Maintenance; no breeches or penetrations noted or found.</p> <p>Education & Systematic Change: Maintenance Staff & Management Team were educated on or before 08/06/2015 by Administrator on contractors entering facility to perform required work. Contractors are required to check in with; 1) Director of Maintenance, 2) Maintenance Assistant, 3) Administrator, 4) Director of Nursing, and/or 5) Receptionist prior to starting work. Contractors will</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 8-6-15
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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.

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K 025	<p>Continued From page 1</p> <p>Based on observation and interview, the facility failed to ensure smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 109 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on July 17, 2015 at approximately 11:30 AM, observation of the smoke barrier above the cross corridor doors near the Health Information office revealed an unsealed 1 inch circular hole penetrating through the wall. When asked, the Maintenance Supervisor stated they were unaware of the unsealed penetration.</p> <p>Actual NFPA standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p>	K 025	<p>be educated on Smoke Barriers and penetration of smoke barriers. Any smoke barriers needing to be penetrated will be immediately sealed by contractor and/or Director of Maintenance with fire rated sealant.</p> <p>Audits & Monitors: Beginning the week of 08/03/2015 inspection audits of all smoke barriers will be completed by Director of Maintenance or designee. These audits will occur weekly x 1 month and monthly x 2 months.</p> <p>Date of Compliance 08/06/2015</p>	

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K 025	Continued From page 2 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier	K 025		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that smoke compartment doors equipped with positive latching hardware were maintained. Failure to ensure existing positive latching hardware would allow smoke and dangerous gases to pass freely between smoke compartments. This deficient	K 027	K027 Identified: Therapy Center corridor doors were adjusted and inspected for proper closure by Director of Maintenance on 08/04/2015. Dining Room corridor doors were adjusted and inspected for proper closure by Director of Maintenance on 08/04/2015. Fire rated weather-strip was ordered on 08/04/2015 by Director of Maintenance to replace seals on Therapy and Dining room corridor doors.	

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K 027	<p>Continued From page 3 practice affected 17 residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 109 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 17, 2015 from 9:30 PM to 3:00 PM, observation and operational testing revealed the corridor doors to both entrances of the Therapy Center would not seal when released from the magnetic holder leaving a 1 inch gap between the doors.</p> <p>2) During the facility tour conducted on July 17, 2015 from 9:30 PM to 3:00 PM, observation and operational testing revealed the corridor doors leading to the Dining room would not seal when released from the magnetic holder leaving a 1 inch gap between the doors.</p> <p>Actual NFPA standard: 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.</p> <p>4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements</p>	K 027	<p>Audits: Facility Wide: An inspection of all smoke compartment and self-closing or automatic closing doors were completed by Director of Maintenance on or before 08/06/2015, no other issues noted or found.</p> <p>Fire rated weather-strip was ordered on 08/04/2015 by Director of Maintenance to replace seals on all self-closing or automatic closing doors.</p> <p>Education & Systematic Change: Maintenance staff & Management Team were educated by Administrator on or before 08/06/2015 on self-closing or automatic doors functioning and sealing properly. Staff was educated on reporting any door malfunctions to Director of Maintenance and/or Maintenance Assistant immediately.</p> <p>Audits & Monitors: Beginning the week of 08/03/2015, an audit of all self-closing or automatic closing doors properly closing & sealing will be completed by Director of Maintenance or designee. These audits will occur weekly x 1 month and monthly x 2 months.</p> <p>Date of Compliance 08/06/2015</p>	

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K 027 K 029 SS=F	Continued From page 4 or as directed by the authority having jurisdiction. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation and operational testing, it was determined that the facility did not ensure that hazardous area rooms were constructed with self closing doors that were smoke-resistive. Hazardous area doors that are not smoke resistive can allow smoke and fire gasses to move rapidly in the event of a fire. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 109 on the day of the survey. Findings Include During the facility tour July 17, 2015 at approximately 2:00 PM, observation of the double doors leading from dining room to the kitchen revealed a kick-down style door stops installed on both doors impeding closure of the doors. Operational testing revealed the doors leading to and from the kitchen area were swinging style	K 027 K 029	K029 Identified: On 07/22/2015 purchase order was approved and sent to vendor to replace swing style kitchen doors leading from kitchen into dining room. New metal, self-closing doors are scheduled to be installed on or before 08/13/2015. Audits: Facility Wide: A facility wide audit of all self-closing or automatic closing doors and the use of any type of door stop was completed by Maintenance Staff on or before 08/06/2015. No identified issues noted or door stops found. Education & Systematic Change: Maintenance staff & Management Team were educated by Administrator on the use of door stops on all fire doors. Doors stop are not allowed to be used on any fire doors throughout the facility. Audits & Monitors: Beginning the week of 08/03/2015, an audit of all self-closing or automatic closing doors will be completed by Director of Maintenance or designee. These audits will occur weekly x 1 month and monthly x 2 months. Date of Compliance 08/06/2015	

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K 029	Continued From page 5 solid core doors with vision panels that did not seal when completely closed leaving an approximate 1 1/2 inch gap between the doors. When asked, the Maintenance Supervisor revealed the facility was aware of the kick-down door stops on the double doors but was unaware the doors had to be smoke resistive. Actual NFPA standard: 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more	K 029		

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K 029	Continued From page 6 than 48 in. (122 cm) above the bottom of the door. 3.3.13.2 Area, Hazardous.	K 029		
K 062 SS=E	An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to provide proper maintenance of sprinkler systems could result in the system not performing as designed during a fire event. This deficient practice affected 16 residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds and had a census of 68 on the day of the survey. Findings include: 1.) During the facility tour on July 17, 2015 between 9:30 AM and 3:00 PM, observation of the Director of Nursing office in the 400 hallway revealed the sprinkler head loaded with excessive dust and dirt build up.	K 062	K062 Identified: Sprinkler Head in Director of Nurses office was cleaned by Maintenance Assistant on 07/22/2015. Audits: Facility Wide: All sprinkler heads throughout the facility was inspected and/or cleaned by Maintenance Assistant on or before 08/06/2015. Education & Systematic Change: Maintenance staff & Management Team were educated by Administrator about reporting dirty or dusty sprinkler heads immediately to Maintenance Department. Sprinkler Head will be cleaned quarterly by Maintenance Department beginning Quarter 3 with documentation on file. Audits & Monitors: Beginning the week of 08/03/2015, an audit of all sprinkler heads will be completed by Director of Maintenance or designee to insure cleanliness and functional ability. These audits will occur weekly x1 month and monthly x 2 months.	

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K 062	Continued From page 7 2.) During the facility tour on July 17, 2015 between 9:30 AM and 3:00 PM, observation of the Central Supply room in the 700 hallway revealed the sprinkler heads loaded with excessive dust and dirt build up. When asked, the Maintenance Supervisor stated they were unaware of the dirty sprinkler head. Actual NFPA standard: NFPA 25 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. 2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected.	K 062	Date of Compliance 08/06/2015	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical systems were	K 147	K147 Identified: Chairs and fan were removed from the storage room near TV lounge unblocking the electrical panel on 07/17/2015.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2015	
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
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K 147	<p>Continued From page 8</p> <p>accessible in accordance with NFPA 70. Failure to maintain clear access to electrical equipment would hinder equipment service in an emergency event. This deficient practice affected 7 residents in the TV lounge, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds with a census of 109 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 17, 2015 at approximately 10:30 AM, observation of the storage room near TV lounge revealed two electrical panels were blocked by chairs and a fan. When asked, the Maintenance Supervisor stated that the facility was unaware of the blocked electrical panels</p> <p>Actual NFPA standard: NFPA 70 110.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a),</p>	K 147	<p>Audits: Facility Wide: Director of Maintenance conducted a facility inspection of all electrical panels to insure they were free of obstructions. No issues noted.</p> <p>Education & Systematic Change: Maintenance Staff & Management Team were educated on or before 08/06/2015 on electrical panels throughout the facility being free from all obstruction and accessible at all times.</p> <p>Use of storage room was moved on or before 08/06/2015. Room is clear of any obstruction.</p> <p>Audits & Monitors: Beginning the week 08/03/2015, an audit of all electrical panels being free and clear of obstructions will be conducted by Director of Maintenance or Designee. These audits will occur weekly x1 month and monthly x2 months.</p> <p>Date of Compliance 08/06/2015</p>	

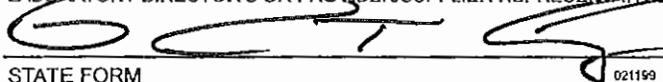
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story Type V (III) construction completed in March 1997. The facility is fully sprinklered and has a complete fire alarm system with smoke detectors throughout. There is an upper level of the facility and is only used for classrooms, medical records, marketing and board room. The facility is currently licensed for 139 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 16, 2015 - July 17, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	C 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Meridian Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
C 227	<p>02.106,01,a GENERAL REQUIREMENTS</p> <p>01. General Requirements. General requirements for the fire and life safety standards for a health care facility are:</p> <p>a. The facility shall be structurally sound, maintained and equipped to assure the safety of patients/ residents, employees and the public.</p>	C 227	<p>C227 Identified: 4' x 3' section of soffit was repaired by Director of Maintenance on 08/04/2015.</p> <p>Audits: Facility Wide: Exterior of facility was inspected by Director of Maintenance on 08/04/2015, no other separating soffits or issues noted.</p>	

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



ADMINISTRATOR

8-6-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2015
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C 227	Continued From Page 1 This RULE: is not met as evidenced by: Based on observation and interview the facility failed to maintain the structural integrity of the facility. This deficient practice could allow smoke and gases to enter the open space of the underside of the exterior roof and spread throughout the facility affecting 25 residents, staff and visitors on the date of survey. The facility is licensed for 139 SNF/NF beds with a census of 109 on the day of survey. Findings include: During the facility tour on July 17, 2015 at approximately 3:00 PM, observation of the exterior portion of the 100 hallway on the east side of the facility revealed an approximate 4' x 3' section of the soffit separating from the roof assembly exposing the interior portion of the facility rafter beams. When asked, the Maintenance Supervisor stated the facility was aware of the damaged soffit.	C 227	Education & Systematic Change: Maintenance Staff & Management Team were educated by Administrator on or before 08/06/2015 on identifying and reporting exterior repairs and/or maintenance issues immediately. Audits & Monitors: Beginning the week of 08/03/2015, an audit of exterior building, including soffits will be completed by Director of Maintenance or Designee. These audits will occur weekly x1 month and monthly x2 months. Date of Compliance 08/03/2015	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.