



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

August 17, 2016

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 **August 10, 2016**, 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

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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 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 30, 2016**. Failure to submit an acceptable PoC by **August 30, 2016**, may result in the imposition of civil monetary penalties by **September 19, 2016**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **September 14, 2016**, (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 **September 14, 2016**. A change in the seriousness of the deficiencies on **September 14, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 14, 2016**, includes the following:

Denial of payment for new admissions effective **November 10, 2016**.  
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 **February 10, 2017**, 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 **August 10, 2016**, 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.

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Informational Letter #2001-10 can also be found on the Internet at:

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

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 30, 2016**. If your request for informal dispute resolution is received after **August 30, 2016**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

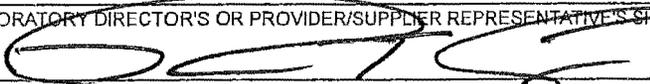
NE/lj  
Enclosures

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

PRINTED: 08/16/2016  
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  08/10/2016
NAME OF PROVIDER OR SUPPLIER  MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642	
(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
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 detection and fire dampers 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 August 10, 2016. 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:  Nate Elkins, Supervisor Facility Fire Safety & Construction Program  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction Program		"This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction Genesis 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."	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure the rated wall that separated the skilled nursing facility and the assisted living facility was maintained without penetrations. Failure to maintain the rated separation wall could allow fire and smoke to penetrate through the wall and endanger both occupancies. This deficient	K 012		

RECEIVED  
AUG 30 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 8-30-2016

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 012	<p>Continued From page 1</p> <p>practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds with a census of 93 on the day of the survey.</p> <p>Findings Include:</p> <p>During the facility tour on August 10, 2016 at approximately 1:30 PM, observation of the wall separating the Skilled Nursing Facility and the Assisted Living Facility reveled a 2 inch by 2 inch square penetration. When asked, the Maintenance Supervisor stated the facility was unaware of the penetration.</p> <p>Actual NFPA standard: 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustibile supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>8.2.1* Construction.</p>	K 012	<p><b>K 012</b></p> <p><b>Identified:</b> 2" X 2" square penetration in wall separating the Assisted Living &amp; Skilled Nursing Facility was repaired by Director of Maintenance on 08/23/2016.</p> <p><b>Audits: Facility Wide:</b> Smoke barrier walls were inspected by Director of Maintenance or designee on or before 08/26/2016, penetrations were repaired immediately.</p> <p><b>Education &amp; Systematic Change:</b> A letter was mailed to facility contractors, vendors, and outside contracting services by Administrator on or before 09/02/2016. Instructions in the letter include; 1) Contractors are to check in with Administrator, Director of Maintenance, Director of Nurses, or Receptionist prior to starting any work (emergency work excluded) 2) Detailed guidelines regarding smoke wall barriers and their obligation to notify or repair breaches with fire rated sealant upon completion of work.</p> <p>Management team was educated by Administrator on or before 08/31/2016 regarding contracted work performed in the center-notification of</p>	
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K 012	Continued From page 2 Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided 8.2.2 Compartmentation. 8.2.2.1 Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke. 8.2.2.2* Fire compartments shall be formed with fire barriers that are continuous from outside wall to outside wall, from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Walls used as fire barriers shall comply with Chapter 3 of NFPA 221, Standard for Fire Walls and Fire Barrier Walls. The NFPA 221 limitation on	K 012	contractors performing work needs to be communicated to Director of Maintenance, Administrator, Director of Nurses, or Receptionist if management team witnesses contractors in the center.  <b>Audits &amp; Monitors:</b> Beginning the week of 09/05/2016 inspection audits of all smoke barriers/walls will be completed by the Director of Maintenance or designee. These audits will occur weekly X 1 month then monthly X 2 months.  <b>DATE OF COMPLIANCE:</b> 09/14/2016	

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K 012	Continued From page 3 percentage width of openings shall not apply. Exception: A fire 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 has a fire resistance rating not less than that of the fire barrier.	K 012		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments. This deficient practice has the potential to affect all residents, staff, and visitors on the date of survey. The facility is licensed for	K 018	<p><b>K 018</b></p> <p><u>Identified:</u> 1) Doors leading into the dining room were adjusted and repaired to close and seal properly by Maintenance Assistant on 08/24/2016.</p> <p>2) Object blocking housekeeping room on 500 hallway was removed by Maintenance Director on 08/11/2016.</p> <p>3) Decorations above door opening leading into resident lounges on 200 &amp; 300 Hallways were removed by Director of Recreation on 08/11/2016.</p> <p>4) Warped door leading into room #205 causing the 1" gap was removed and replaced by Director of Maintenance on 08/29/2016.</p> <p>5) Kick Wedges were removed from training room and upstairs conference room door leading into corridor by Administrator on 08/12/2016.</p> <p>6) Door protecting elevator was adjusted to close and latch properly by Maintenance Assistant on 08/24/2016.</p>	

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K 018	Continued From page 4 139 SNF/NF beds with a census of 93 on the day of survey.  Findings include:  1.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation and operational testing of the doors leading to the dining room revealed the doors would not close and seal properly when released from the magnetic hold open devices leaving an approximate 1-1/2 gap between the doors.  2.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation of the door leading to the Housekeeping room in the 500 hallway revealed an object placed in front of the self-closing door to keep the door from closing.  3.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation and operational testing of the door leading to the Lounge area in the 200 hallway revealed decorations affixed above the door opening impeding the door from closing and latching properly when released from magnetic hold-open device.  4.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation and operational testing of the door leading to the Lounge area in the 300 hallway revealed decorations affixed above the door opening impeding the door from closing and latching properly when released from magnetic hold-open device.  5.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation and	K 018	7) Therapy Center door was adjusted to close and latch properly by Maintenance Assistant on 08/24/2016.  <u>Audits: Facility Wide:</u> A facility wide audit was conducted by Director of Maintenance on or before 08/26/2016 to insure self-closing doors closed and latched properly when released from magnetic hold open device with no further issues noted or found.  A facility wide audit was conducted on or before 08/26/2016 by Director of Maintenance to insure kick-wedges and other objects were not being used to hold open self-closing doors. No further issues noted or found.  A facility wide audit was conducted on or before 08/26/2016 by Director of Recreation to insure decorations were not placed in areas that impede self-closing doors to shut and latch properly. No further issues noted or found.  A facility wide audit was conducted on or before 08/26/2016 by Director of Maintenance to insure doors close without gaps. Issues were resolved immediately by Director of	

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K 018	<p>Continued From page 5</p> <p>operational testing of the door leading to room #205 revealed an approximate 1 inch gap between the door jamb and the face of the door.</p> <p>6.) During the facility tour on August 10, 2016, from 1:00 PM to 4:30 PM, observation of the self-closing door leading from the upstairs Conference room to the corridor revealed a kick-wedge holding the door open.</p> <p>7.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation of the self-closing door leading to the Training room from the corridor located on the second floor revealed a kick-wedge holding the door open.</p> <p>8.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation and operational testing of the fire door protecting the elevator revealed the door would not close and latch properly when released from the magnetic hold-open device</p> <p>9.) During the facility tour on August 10, 2016 from 1:00 PM to 4:30 PM, observation of the self-closing door leading to the Therapy Center from the 500 hallway corridor the door would not self close and latch properly when activated from the magnetic hold open device.</p> <p>When asked, the Maintenance Supervisor stated the facility was unaware of any of the deficiencies cited above.</p> <p>Actual NFPA standard: 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or</p>	K 018	<p>Maintenance or Maintenance Assistant.</p> <p><b><u>Education &amp; Systematic Change:</u></b></p> <p>Facility staff were educated by Nurse Practice Educator on or before 09/09/2016 on: 1) Usage of Kick-Wedges or other objects to hold open ANY doors is prohibited. 2) Decorations of any sort cannot be place above or in areas that impede self-closing doors to shut and latch properly. 3) Facility Staff to report issues with self-closing doors to Director of Maintenance, Maintenance Assistant, Administrator, and/or Director of Nurses immediately.</p> <p>Recreation staff was educated by Administrator on 08/30/2016 regarding the usage and placement of decorations above or near self-closing doors that impede the doors to close and latch properly.</p> <p>Staffing Coordinator, Central Supply Coordinator and Nurse Practice Educator were educated by Administrator on 08/26/2016 regarding the use of the kick wedge</p>	
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K 018	Continued From page 6 hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept	K 018	blocking open the self-closing door leading from the upstairs conference room to the corridor being prohibited.  Seven new magnetic holders will be installed by Crane Alarm Company in areas identified. Bid was received by Administrator on 08/29/2016. Schedule of work to be completed by 09/30/2016.  <u>Audits &amp; Monitors:</u>  Beginning the week of 09/05/2016 an audit will be conducted by Director of Maintenance or designee to insure self-closing doors properly close and latch when released from the magnetic hold devise. These audits will be conducted weekly X 1 month then monthly X 2 months.  Beginning the week of 09/05/2016 an audit will be conducted by the Director of Recreation or designee to insure decorations are not affixed above or in an area that would impede self-closing doors to close and latch properly when released from magnetic hold-open device. These audits will be		

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NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>
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K 018	Continued From page 7 in service  8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 018	conducted weekly X 1 month then monthly X 2 months.  Beginning the week of 09/05/2016, an audit will be conducted by the Administrator or designee to insure kick-wedges or other objects are not used to hold any doors open. These audits will be conducted weekly X 1 month then monthly X 2 months.  Beginning the week of 09/05/2016, an audit will be conducted by the Director of Maintenance or designee to insure doors shut tightly and without any gaps between the door jamb and face of the door. These audits will be conducted weekly X 1 month then monthly X 2 months.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure smoke compartments were maintained. Failure to ensure continuity in smoke barriers would allow smoke and dangerous gases to communicate freely between smoke compartments endangering protection in place. This deficient practice affected 19 residents, staff,	K 025	<b>Date of Compliance:</b> <b>09/14/2016</b>	

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NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1361 WEST PINE AVENUE MERIDIAN, ID 83642</b>	
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K 025	<p>Continued From page 8 and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds with a census of 93 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on August 10, 2016 at approximately 1:00 PM, observation of the shower room between rooms 409 and 411 in the 400 hallway revealed a 1 inch circular penetration through the ceiling.</p> <p>2.) During the facility tour on August 10, 2016 at approximately 1:30 PM, observation of room 411 revealed a missing 2 feet by 2 feet ceiling tile.</p> <p>When asked about the penetrations and ceiling tile missing, the Maintenance Supervisor stated the facility was unaware of the penetrations and missing ceiling tile.</p> <p>Actual NFPA Standard:</p> <p>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</p>	K 025	<p><b>K 025</b></p> <p><b>Identified:</b> 1) 1" inch circular penetration through the ceiling on the 400 hallway between rooms 409 and 411 was repaired by the Director of Maintenance on 08/12/2016.</p> <p>2' X 2' missing ceiling tile in room 411 was replaced by Director of Maintenance on 08/12/2016.</p> <p><b>Audits: Facility Wide:</b> Ceiling tiles throughout facility were inspected for penetrations and/or missing tiles by Director of Maintenance on or before 08/26/2016. Issued were corrected immediately by Maintenance Director or Maintenance Assistant.</p> <p><b>Education &amp; Systematic Change:</b> Facility staff were educated by Nurse Practice Educator or designee on or before 09/09/2016 regarding notification to Maintenance Department, Administrator, or Director of Nurses if ceiling tiles are missing or have penetrations.</p> <p>Contracted services were notified via letter from Administrator by</p>	

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K 025	Continued From page 9 compartments adjacent to the smoke barrier.  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	09/02/2016 insure ceiling tiles are properly placed back and or replaced if penetrations occur during work. Contractors are required to notify Maintenance Department, Administrator, or Director of Nurses if ceiling tiles are damaged or need to be replaced.  <b><u>Audits &amp; Monitors:</u></b> Beginning the week of 09/05/2016 ceiling tiles will be inspected for penetrations or missing tiles by Maintenance Director or designee. These audits will occur weekly X 1 week then monthly X 2 months.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with 0 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, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and	K 029	<b>Date of Compliance:</b> <b>09/14/2016</b>  <b>K 029</b>  <b><u>Identified:</u></b> 1) Upstairs storage room self-closing device was re-attached by Director of Maintenance on 08/12/2016.  2) Rooms #411 & #415 were cleaned out to insure proper door closure and combustible materials were discarded	

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K 029	<p>Continued From page 10</p> <p>hinder egress of occupants 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 with a census of 93 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on August 10, 2016 at approximately 3:30 PM, observation of the door leading into the upstairs storage room revealed the door was detached from the self-closing device. Upon operational testing it was confirmed the door would not self-close. When asked, the Maintenance Supervisor stated the facility was aware the door was disconnected from the self-closing device.</p> <p>2.) During the facility tour on August 10, 2016 at approximately 4:00 PM, observation and operational testing of the doors to rooms #411 and #415 did not self-close. It was observed that these rooms were being utilized for storage of combustible materials that posed a degree of hazard greater than the general occupancy of the facility. When asked, the Maintenance Supervisor stated the facility was aware these doors were required to self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. 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.</p>	K 029	<p>by Director of Housekeeping on 08/12/2016.</p> <p><b>Audits: Facility Wide:</b> 1) A facility wide audit was completed by Director of Maintenance on or before 08/26/2016 to insure self-closing door devices were connected and properly functioning. Issues were corrected immediately by Director of Maintenance.</p> <p>2) A facility wide audit of storage rooms and vacant resident rooms was completed by Director of Housekeeping on or before 08/29/2016 to insure rooms were not cluttered or potentially pose a greater fire risk to the facility. Issues were corrected immediately by Director of Housekeeping.</p> <p><b>Education &amp; Systematic Change:</b> Facility staff were educated on or before 09/09/2016 by Nurse Practice Educator or Designee on: 1) Doors with self-closing devices must not be tampered with or disabled. Staff that observes a self-closing device disabled or not functional must report to Director of Maintenance, Maintenance Assistant, or Administrator immediately.</p>	

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K 029	Continued From page 11  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 NFPA 101 LIFE SAFETY CODE STANDARD  Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by:	K 029	2) Facility Staff were educated by Nurse Practice Educator or Designee on or before 09/09/2016 regarding storage areas: Storage items cannot impede a self-closing door or any other door to shut and latch properly. Storage rooms must not become cluttered as to pose a greater fire risk to the facility.  Storage rooms were updated with key lock handles by Director of Maintenance or Designee on or before 09/14/2016.  <u>Audits &amp; Monitors:</u> Beginning the week of 09/05/2016 an audit of self-closing doors with closing devices will be conducted by Director of Maintenance or Designee to insure self-closing devices are attached and functioning. These audits will be occur weekly X 1 month, then monthly X 2 months.  Beginning the week of 09/05/2016 an audit of storage rooms will be conducted by Director of Housekeeping or designee to insure storage area doors are not impeded by storage material and storage rooms are not cluttered to impose a great risk to the facility. These audits will occur	
K 067 SS=F		K 067		

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K 067	Continued From page 12 Based on record review and interview, the facility failed to complete 4-year interval testing on the dampers as required under NFPA 90A. Failure to ensure dampers will operate to manufacturer's specifications would allow smoke and dangerous gases to pass freely throughout the facility during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 139 SNF/NF beds with a census of 93 on the day of the survey.  Findings include:  During record review conducted on August 10, 2016 from 9:00 AM to 12:00 PM, the facility failed to provide a 4-year interval testing report of the installed fire dampers. When reviewing the fire alarm reports, the documentation stated the facility does have installed fire dampers. When asked, the Maintenance Supervisor stated the facility was unaware of the damper testing requirements.  Actual NFPA standard:  NFPA 90A 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 067	weekly X 1 week, then monthly X 2 months.  <b>Date of Compliance:</b> 09/14/2016  K 067  <b>Identified:</b> 4-year interval testing on the dampers as required under NFPA 90A was conducted on 03/20/2016 by AEI. Documentation was found by Maintenance Director on 08/11/2016.  <b>Audits: Facility Wide:</b> Annual and interval testing/inspection records of facility fire systems was reviewed by Director of Maintenance and Maintenance Assistant on or before 09/02/2016.  <b>Education &amp; Systematic Changes:</b> New Director of Maintenance was educated by former Director of Maintenance (Now Maintenance	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069		

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K 069	<p>Continued From page 13</p> <p>Based on record review and interview, the facility failed to ensure the cooking facility was maintained. Failure to ensure that cooking equipment is maintained could expose personnel to fire risks due to failure of equipment. 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 93 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility records on August 10, 2016 from 9:00 AM to 12:00 PM, revealed missing documentation of the semi-annual kitchen hood suppression system inspection. When asked, the the Maintenance Supervisor stated the kitchen hood suppression system was tested but was not aware of the location of the report.</p> <p>Actual NFPA standard: NFPA 96 11.2 Inspection of Fire-Extinguishing Systems. 11.2.1* An inspection and servicing of the fire-extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons. 11.2.2 All actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire-actuated dampers, shall be checked for proper operation during the inspection in accordance with the manufacturer ' s listed procedures. 11.2.3 In addition to these requirements, the specific inspection requirements of the applicable NFPA standard shall also be followed.</p>	K 069	<p>Assistant) on annual/interval testing/inspections documentation and filing on or before 09/02/2016.</p> <p><b>Audits &amp; Monitors:</b> TELS system alerts Maintenance Director of inspections upcoming and needed. A monthly audit will be conducted by Director of Maintenance and Maintenance Assistant or designee to insure required inspections and/or testing is completed. These audits will occur monthly X 6 months.</p> <p><b>Date of Compliance:</b> 09/14/2016</p> <p><b>K 069</b></p> <p><b>Identified:</b> The semi-annual kitchen hood suppression system inspection was conducted on 06/17/2016 by Taylor Brothers Fire &amp; Safety. Records were located by Director of Maintenance on 08/22/2016.</p>	
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K 069

Continued From page 14  
11.2.4\* Fusible links (including fusible links on fire damper assemblies) and automatic sprinkler heads shall be replaced at least annually, or more frequently if necessary where required by the manufacturer.  
11.2.5 The year of manufacture and the date of installation of the fusible links shall be marked on the system inspection tag. The tag shall be signed or initialed by the installer.  
11.2.6 Other detection devices not including fusible links and automatic sprinklers shall be serviced or replaced in accordance with the manufacturer's recommendations.  
11.2.7 Where automatic bulb-type sprinklers or spray nozzles are used and annual examination shows no buildup of grease or other material on the sprinkler or spray nozzles, annual replacement shall not be required.  
11.2.8 Where required, certificates of inspection and maintenance shall be forwarded to the authority having jurisdiction.

K 147  
SS=F

**NFPA 101 LIFE SAFETY CODE STANDARD**  
Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1  
This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. This deficient practice affected all residents, staff and visitors on the date of survey. The facility is licensed for 139 SNF/NF beds with a census of 93 the day of survey.

Findings include:

1.) During the facility tour on August 10, 2016

K 069

**Audits: Facility Wide:** Annual and interval testing/inspection records of facility fire systems was reviewed by Director of Maintenance and Maintenance Assistant on or before 09/02/2016.

**Education & Systematic Changes:**

New Director of Maintenance was educated by former Director of Maintenance (Now Maintenance Assistant) on annual/interval testing/inspections documentation and filing on or before 09/02/2016.

**Audits & Monitors:** TELS system

alerts Maintenance Director of inspections upcoming and needed. A monthly audit will be conducted by Director of Maintenance and Maintenance Assistant or designee to insure required inspections and/or testing is completed. These audits will occur monthly X 6 months.

K 147

**Date of Compliance:**

**09/14/2016**

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K 147	Continued From page 15 from 1:00 PM to 4:30 PM, observation revealed multiple refrigerators, microwaves, oxygen concentrators plugged into relocatable power taps (RPT) as a substitute for fixed wiring. Based on the number of observations by the surveyors, detailed documentation of the locations was deemed unnecessary and annotated as throughout the entire facility specific areas was deemed unnecessary. When asked, the Maintenance Supervisor stated the facility was aware of the requirements but was unaware the relocatable power taps were being used as fixed wiring.  2.) During the facility tour on August 10, 2016 at approximately 2:00 PM, observation above the false ceiling near the Admissions office revealed an open electric receptacle box with exposed live wiring. When asked, the Maintenance Supervisor stated the facility was unaware of the cover plates missing.  3.) During the facility tour on August 10, 2016 at approximately 2:15 PM, observation above the false ceiling tiles near the intersection of the 700 hallway and the Assisted Living entrance revealed an open electric receptacle box with exposed live wiring. When asked, the Maintenance Supervisor stated the facility was unaware of the cover plates missing.  4.) During the facility tour on August 10, 2016 at approximately 3:30 PM, observation of the Activities room in the 100 hallway revealed an orange extension cord being used as permanent wiring to power a microwave. When asked, the Maintenance Supervisor stated the facility was unaware of the extension cord usage.	K 147	<b>K 147</b> <b>Identified:</b>  1) Refrigerators, microwaves, oxygen concentrators, any medical equipment, and other appliances were unplugged from relocatable power taps (RPT) and plugged into wall electrical outlets by Director of Maintenance on or before 08/26/2016.  2) Open electrical receptacle box with exposed live wire near Admissions office was repaired by Director of Maintenance on 08/22/2016.  3) Open electrical receptacle box with exposed live wire near the intersection of the 700 hallway and the Assisted Living entrance was repaired by Director of Maintenance on 08/22/2016.  4) Orange extension cord used as permanent wiring to power microwave in the activity room on 100 hall was removed by Director of Maintenance on 08/10/2016.	

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K 147	<p>Continued From page 16 Actual NFPA standard: NFPA 70 National Electrical Code 1999 Edition</p> <p>400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</li> <li>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>6. Where installed in raceways, except as otherwise permitted in this Code</li> </ol> <p>Also see UL listings: XBYS Guide information XBZN2 Guide information</p>	K 147	<p><b><u>Audits: Facility Wide:</u></b></p> <ol style="list-style-type: none"> <li>1) A facility wide audit was conducted by the Director of Maintenance on or before 08/26/2016 for the use of relocatable power taps (RPT). Appliances and medical equipment were unplugged from RPT and plugged into wall outlet.</li> <li>2) A facility wide audit was conducted by the Director of Maintenance on or before 08/26/2016 for any open electrical receptacle box and/or exposed wires. No further issues noted or found.</li> <li>3) A facility wide audit was conducted by Director of Maintenance on or before 08/26/2016 for the use of extension cords. No further issues noted or found.</li> </ol> <p><b><u>Education &amp; Systematic Changes:</u></b> Facility staff were educated by the Administrator or designee on or before 09/09/2016 on the proper use of relocatable power taps (RPT), the use of electrical cords are not allowed (other than emergency power outages), and to advise maintenance staff that any exposed electrical boxes or wires immediately.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2016  
FORM APPROVED  
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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  08/10/2016
NAME OF PROVIDER OR SUPPLIER  MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642	
(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
K 147	Continued From page 16 Actual NFPA standard: NFPA 70 National Electrical Code 1999 Edition  400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code  Also see UL listings: XBYS Guide information XBZN2 Guide information	K 147	A letter was sent to resident family members or primary contacts from the Administrator on or before 09/02/2016 advising family of the use of relocatable power taps (RPT) and proper usage.  <b><u>Audits &amp; Monitoring:</u></b> Beginning the week of 09/05/2016, an audit will be conducted by the Director of Maintenance or designee on the use and usage of relocatable power taps (RPT). These audits will occur weekly X 1 month, then monthly X 2 months.  Beginning the week of 09/05/2016, an audit will be conducted by the Director of Maintenance or designee to insure that electrical receptacle	

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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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