



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
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May 13, 2016

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

Provider #: 135125

Dear Mr. Strong:

On **April 29, 2016**, a survey was conducted at Meridian Center Genesis Healthcare by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 23, 2016**. Failure to submit an acceptable PoC by **May 23, 2016**, may result in the imposition of civil monetary penalties by **June 17, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

A civil money penalty 42 CFR §488.430

Denial of payment for new admissions effective **July 28, 2016**. [42 CFR §488.417(a)]

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If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, 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 **October 28, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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 28, 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. 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)

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

This request must be received by **May 23, 2016**. If your request for informal dispute resolution is received after **May 23, 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "Nina Sanderson". The signature is written in a cursive style and is positioned above the typed name.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt
Enclosures

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

PRINTED: 11/30/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2016
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	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from April 25, 2016 to April 29, 2016.</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process conducted on October 20, 2016.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Michael Case, LSW, QIDP Karen Marshall, MS, RD, LD Linda Close, RN Seon-Mi Park, RN Deb Abasciano, RN Ophelia McDaniels, RN</p> <p>Survey Definitions: ABN = Advanced Beneficiary Notice ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status BOM = Business Office Manager C & S = Culture and Sensitivity cm = Centimeters CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed SNF = Skilled Nursing Facility SW = Social Worker TED = Thrombo Embolism Deterrent UA = Urinalysis UM = Unit Manager</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/23/2016

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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F 000	Continued From page 1	F 000			
F 156 SS=D	<p>UTI = Urinary Tract Infection</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>	F 156		6/17/16	

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F 156	<p>Continued From page 2</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were provided advance notice of their right to appeal the termination of coverage for their stay in the SNF. This deficient practice was true for 1 of 3 residents (#21) reviewed for notice of Medicare non-coverage. This failure created the potential for residents to experience financial distress and psychological harm when the resident was not informed of their right to appeal the decision. Findings included:</p> <p>Resident #21's ABN letter documented Resident #21's Medicare coverage would end on 6/4/15. However, the letter did not include a reason for the coverage termination and was not signed by Resident #21.</p> <p>On 4/26/16 at 11:00 am, the BOM said she was not sure why Resident #21's Medicare ended because the reason was not on the ABN form. The BOM also indicated the form was not signed by Resident #21 to acknowledge the resident received the information.</p>	F 156	<p>Residents <input type="checkbox"/> Affected: Resident #21 was notified of her omitted appeal rights by the Administrator on 06/02/2015. The resident did not request any further action.</p> <p>Potential Residents <input type="checkbox"/> Affected: A review of residents whose skilled coverage was terminated during the last 6 months will be completed by the business office manager on or before 05/30/2016. Follow up notifications will be completed by the Administrator or designee on or before 06/17/2017.</p> <p>System Change/Education: Residents who are covered by Medicare will be reviewed in the weekly Utilization Review meeting by the Administrator or Designee to ensure that Non-Coverage Letters are provided per Medicare guidelines beginning the week of 05/30/2016.</p> <p>The Business Office Manager who is responsible for delivering notices was re-educated on Medicare requirements for administering non-coverage letters by the Administrator on 05/24/2016.</p> <p>Monitoring: Beginning the week of 05/30/2016 The</p>		

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F 156	Continued From page 4	F 156	Administrator or Designee will audit 5 residents whose Medicare coverage was terminated to ensure that Medicare Non-coverage notices were provided per Medicare guidelines. These audits will be completed weekly X4 weeks and then monthly x2 months, The results of these audits will be compiled by the Administrator and reported to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the dignity of 1 of 17 (#13) sampled residents residing in the facility and 2 of 2 random residents (#26 and #27) observed dining. This resulted in the potential for a negative effect on residents' self-esteem and others' perceptions of them. Findings include:</p> <p>1. Resident #13 was admitted to the facility with diagnoses including enlarged prostate and hernia repair. Resident #13's 4/14/16 catheter care plan noted the catheter bag was to be in a privacy bag.</p>	F 241	<p>Residents' Affected: Resident's #13, #26, and #27 were assessed by the Licensed Social Worker for any adverse effects related to a breach in dignity on or before 05/20/2016. No adverse side effects noted. Potential Residents' Affected: A center- wide audit will be completed by the Administrator or Designee on or before 06/03/2016 to identify any breaches in resident dignity, including catheter bags uncovered or clothing protectors given to residents without their permission. Any identified concerns will</p>	6/17/16	

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F 241	<p>Continued From page 5</p> <p>On 4/27/16 at 10:10 am, Resident #13 was sitting in his wheelchair in his room and the door to his room was open. His catheter bag was attached to his wheelchair and visible from the doorway. At that time, Resident #13 said a staff had helped him with the catheter tubing and catheter bag.</p> <p>A few minutes later at 10:18 am, UM #19 placed Resident #13's catheter bag in a blue cloth bag and attached the bag to Resident #13's wheelchair. The UM acknowledged the catheter bag was to be in a privacy bag and not visible.</p> <p>2. Staff were not observed to offer clothing protectors to residents prior to placing them on the resident, as follows:</p> <p>The midday meal was observed at the facility on 4/26/16. At 12:05 pm, a visitor to the facility was observed to reach around the kitchen door and obtained 3 terry cloth clothing protectors, which she took to a table where her mother was sitting. The visitor placed one clothing protector on her mother and set the remaining two on the table.</p> <p>CNA #20 approached and asked if the visitor was going to use the other two clothing protectors. CNA #20 took the clothing protectors and approached Resident #27 from behind. CNA #20 placed a clothing protector on Resident #27 from behind without speaking to him to ask permission or to inform him of what she was doing.</p> <p>CNA #20 then approached a different table where Resident #26 was seated. CNA #20 approached Resident #26 from behind and placed the second clothing protector around her</p>	F 241	<p>be addressed immediately and on site education will be provided to staff as needed.</p> <p>System Changes/Education: Center staff will be re-educated on providing resident dignity including covering catheter bags, and obtaining resident permission prior to providing clothing protectors by the Director of Nursing or Designee on or before 06/03/2016.</p> <p>Quality of Life Rounds (Members of IDT and Director Care Staff rounding to identify (but not limited to); dignity ,care improvements, therapy recommendations, privacy, Involvement in Center activities, environmental Issues or improvements, functional mobility) will be implemented beginning the week of 05/30/2016 to identify and correct breaches in resident dignity, including uncovered catheter bags.</p> <p>An ongoing monthly dining room calendar will be implemented by 5/30/16 to identify managers who will supervise the dining room service seven days a week. Dining room supervision will include observations to ensure that clothing protectors are offered to residents. These rounds will be implemented starting the week of 05/30/2016. Unit Managers will educate staff immediately if breaches of dignity occur.</p> <p>Monitoring: Beginning the week of 05/30/2016 a Center dignity audit/ round will be completed by the Administrator or Designee to ensure catheter bags are</p>		

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F 241	Continued From page 6 neck without speaking to her to ask permission or to inform her of what she was doing. During an interview on 4/28/16 at 9:42 am, RN #3, the Unit Manager, stated some residents had requested a clothing protector for every meal. For those residents the CNA might not ask if they would like a clothing protector prior to providing one, but they would still be expected to inform the resident of their presence and what they were doing prior to placing the clothing protector on the resident.	F 241	covered. These rounds will be completed daily for 2 weeks and weekly x 2weeks and monthly X 2 months. The administrator or designee will conduct random meal audits weekly x4 weeks and then monthly x2 weeks or until substantial compliance is achieved to ensure that clothing protectors are offered to residents. The Administrator will compile the results of these audits and report them to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents' call lights were within their reach. This was true for 1 of 17 (#9) sampled residents residing in the facility and 1 of 2 (#26) random residents. This created the potential for harm if residents needing assistance or in distress were unable to request help. Findings included:	F 246	Residents <input type="checkbox"/> Affected: Resident #9 and resident #26 were assessed by the unit manager on 05/20/2016, for any adverse effect associated with being unable to reach their call light. Follow-up was completed as needed. Potential Residents <input type="checkbox"/> Affected: Center rounds were completed by the	6/17/16	

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F 246	<p>Continued From page 7</p> <p>1. Random Resident #26 was admitted to the facility with diagnoses including dementia. Her 2/25/16 self care deficit care plan documented equipment was to be within easy reach of her.</p> <p>On 4/25/16 at 10:15, 11:09, 11:20, and 11:57 am, Resident #26 was observed in her room lying on her bed. The call light mechanism was attached to the call light wall receptacle approximately 24 inches above her right arm.</p> <p>On 4/26/16 at 10:51 am, Resident #26 was in her room, lying on her bed. When interviewed, Resident #26 attempted, but was not able to, activate her call light. At that time, UM #3 removed the call light from the wall receptacle and placed it within her reach. The UM stated she had checked Resident #26's call light earlier in the day and at that time it was within her reach.</p> <p>2. On 4/25/16 at 10:27 am, Resident #9 was in her room seated in her wheelchair to the right side of her bed. Resident #9 said she was sitting on her catheter and was experiencing pain. When asked if she could use her call light, Resident #9 tried to look behind her left side where the call light was located. The call light extension was tied to the upper right side of the bed rail behind her wheelchair. Resident #9 was unable to turn her upper body to her left side or move around in her wheelchair to reach the call light.</p> <p>On 4/25/16 at 11:10 am, Resident #9 was sitting in her wheelchair in the same location as observed earlier. The call light extension was tied to the upper right side of bed rail out of her reach.</p>	F 246	<p>Administrator or Designee on or before 05/30/2016 to ensure that resident call lights were within reach. Any identified areas of concern were immediately addressed.</p> <p>System Change/Education: Residents will be educated during the June 16, 2016 resident council meeting by the administrator or director of nursing on their right to have call lights accessible while in their rooms and to report any concerns related to call lights not being in reach to any staff at any time. Center staff will be re-educated by the Director of Nursing or Designee on the importance of ensuring that residents are able to reach their call lights to alert staff of their needs, on or before 06/03/2016. Beginning the week of 05/30/2016 weekly Quality of Life rounds were implemented by the Director of Nursing to increase resident supervision, and to validate that call lights are within reach.</p> <p>Monitoring: Beginning the week of 05/30/2016 the Administrator or Designee will complete a Center rounds to ensure that call lights are within reach. These rounds will be completed daily for 2 weeks and weekly 2weeks and monthly X 2 months. The results of these audits will be compiled by the Administrator and reported to the QAPI committee monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.</p>		

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F 246	Continued From page 8	F 246			
F 278 SS=D	<p>On 4/27/16 at 10:50 am, LN #8 said Resident #9 would not be able to reach the call light extension when the call light extension was tied to the upper right side rail behind Resident #9 while she was seated in the wheelchair.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p>	F 278		6/17/16	

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F 278	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to ensure accurate assessments were completed for 2 of 17 (#5 & #14) sampled residents residing in the facility. The facility failed to accurately assess Resident #5's speech and Resident #14's UTI status. This resulted in the potential for residents' psychosocial and health care needs to go unmet. Findings included:</p> <p>1. Resident #5 was re-admitted to the facility with diagnoses including right side hemiplegia and expressive aphasia.</p> <p>Resident #5's 10/8/15 annual MDS assessment documented speech clarity was unclear. Resident #5's 4/11/16 quarterly MDS assessment documented speech clarity was "No Speech - absence of spoken words."</p> <p>Resident #5's 4/7/16 expressive aphasia care plan included interventions to ask simple yes or no questions and validate her message by repeating aloud.</p> <p>On 4/25/16 at 10:21 am, Resident #5 said to the surveyor, "You look like my Mom." At 11:11 am, she was observed in the dining room and when staff asked if she wanted more to drink, she replied, "yes." At 3:00 pm when interviewed and asked if she was comfortable in her bed, she replied "okay."</p> <p>On 4/26/16 at 12:27 pm, the surveyor asked Resident #5 about the remaining food on her plate. She replied, "I'm full" and "do not want to</p>	F 278	<p>Residents <input type="checkbox"/> Affected: Resident #5 and #14 <input type="checkbox"/>s MDS were reviewed and modified by the MDS coordinator on or before 05/30/2016.</p> <p>Potential Residents <input type="checkbox"/> Affected: A review of MDS assessments completed over the last 30 days was completed by the Director of Nursing or Designee on or before 05/30/2016 to ensure accuracy. A review of the infection control log for the last 90 days to identify residents with UTI <input type="checkbox"/>s and ensure their MDS assessments accurately reflected any UTI was completed as part of the MDS review. Current resident MDS assessments were reviewed to identify residents with no speech on their MDS to ensure accuracy. Modifications were completed by the MDS coordinator as indicated on or before 06/17/2016.</p> <p>System Changes/Education: The MDS coders will be re-educated by the RAI Specialist of Clinical Reimbursement on 05/24/2016 regarding accurate coding of MDS assessments including UTI and speech ability.</p> <p>MDS coders will attend morning, clinical meeting and will be notified at that time of any new UTI <input type="checkbox"/>s or new residents with speech inability or new onset of speech inability.</p> <p>Monitoring: Beginning the week of 05/30/2016, The Director of Nursing or Designee will review 5 MDS <input type="checkbox"/>s for accuracy in coding.</p>		

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F 278	Continued From page 10 eat anything else." On 4/27/16 at 11:38 am, the MDS coordinator was interviewed and said the 4/11/16 MDS assessment noting Resident #5 had "no speech" was based on information in the 4/11/16 nurses' assessment document. 2. Resident #14's physician order, dated 4/4/16, documented ciprofloxacin for the treatment of a UTI. Resident #14's urine laboratory culture results indicated the presence of the bacteria Klebsiella pneumoniae. Resident #14's 4/7/16 Quarterly MDS assessment documented Resident #14 had not had a UTI in the last 30 days. On 4/28/16 the DON said Resident #14's condition was not correctly documented on the MDS assessment.	F 278	These audits will be done weekly X4 weeks and then monthly X2. The Director of Nursing will compile the results of these audits and report to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and oversight.		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure: a) Residents received catheter care necessary to	F 309	Residents Affected: Resident #9 was provided with a catheter leg strap by the Unit Manager on 05/20/2016.	6/17/16	

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F 309	<p>Continued From page 11</p> <p>prevent harm. This was true for 1 of 8 residents (#9) reviewed who had indwelling catheter. This resulted in harm to Resident #9, when a catheter strap was not used and she experienced ongoing pain due to the catheter tubing pulling at the insertion site; b) failed to follow physician orders. This was true for 1 of 17 sampled residents and had the potential to cause more than minimal harm when compression socks to treat edema were not applied; c) failed to ensure medications were available. This was true for 1 of 25 residents (#25) sampled for medication availability and had the potential to cause more than minimal harm if a resident experienced increased pain and migraine headaches due to a lack of prescribed medications. Findings include:</p> <p>1. Resident #9's Physician Order and care plan for April 2016 documented she was to have a catheter leg strap daily.</p> <p>On 4/25/2016 at 10:27 am, Resident #9 was observed in her room seated in the wheelchair to the right side of her bed. She said she was sitting on her catheter tubing and was experiencing pain in her lower abdomen area. Resident #9 had a continuous indwelling urine catheter with a urine collection bag hanging on the right side of her wheelchair. The surveyor asked Resident #9 to press the call light for staff assistance. Resident #9 was unable to reach the call light where it was tied to the bed rail. Resident #9 appeared to be in pain.</p> <p>On 4/26/16 at 9:20 am, Resident #9's incontinence care was observed. CNA #9 and CNA #10 transferred her from the wheelchair to the bed with a mechanical Hoyer lift. A thumbnail</p>	F 309	<p>Resident #9 had a comprehensive pain assessment completed by the Unit Manager on 05/20/2016. The results of this assessment were reviewed with the resident s attending physician on 05/24/2016. The attending physician reassessed the resident on 05/24/2016 with new orders implemented as indicated.</p> <p>CNA #9 and #10 were re-educated by the Director of Nursing or Designee on the requirements for reporting new pain and or change of condition to the licensed nurse on or before 05/30/2016.</p> <p>Resident #16 had a comprehensive pain assessment completed by Unit Manager on 05/20/2016. The results of this assessment were reviewed with the resident s attending physician by the Unit Manager on 05/20/2016. New orders for pain medication were implemented as indicated.</p> <p>Resident #16 s care plan was updated by the Unit Manager on 05/20/2016 to reflect the potential for pain due to left heel deep tissue injury.</p> <p>LN #17 was re-educated by the Director of Nursing on 05/18/2016 related to the assessment of pain prior to completing treatments.</p> <p>Resident #8 was assessed by the unit manager on 05/20/2016 for edema, or</p>		

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F 309	<p>Continued From page 12</p> <p>size blood clot and whitish sediments were noted inside of Resident #9's indwelling urine catheter tubing. The urine collection bag attached to the end of tubing was one third full. Resident #9 was tearful and repeatedly said it "hurts down there" while pointing to the lower abdominal area and the indwelling urine catheter insertion site. CNA #10 stated the catheter was leaking when she saw Resident #9's wet underwear during the care. Resident #9 continuously complained of pain at her catheter insertion site during the transfer from her wheelchair to the bed and during the incontinent care. Whenever the catheter was moved and touched, she said, "Ouch ". During the observation, there was not a leg strap to anchor the catheter to Resident #9's upper thigh to prevent tension or irritation caused by the catheter and the weight of the urine collection bag. CNA #10 said Resident #9 had been frequently complaining of pain at her catheter insertion site and lower abdominal area. CNA #9 and CNA #10 finished Resident #9's incontinence care and left room at 9:35 am. Resident #9 said she was still having pain "down there where the catheter stuff is" while pointing at her lower abdominal area and the catheter insertion site. She further stated her pain was a little better since the catheter was not moving around anymore.</p> <p>On 4/27/16 at 10:35 am and 10:50 am, LN #8 said nursing and CNA staff should have followed the care plan to make sure Resident #9's leg strap was secured to her leg and the leg strap was used to prevent the catheter from being pulled out which could cause pain.</p> <p>Resident #9 was harmed when she experienced ongoing pain when staff failed to follow her</p>	F 309	<p>any other adverse effect associated with not wearing ted hose. No negative effects were noted.</p> <p>Resident #25 was discharged from Meridian Center on 11/20/2015.</p> <p>Potential Residents Affected: Residents with indwelling urinary catheters will be reviewed by the Director of Nursing or designee for catheter straps as ordered, and any catheter associated pain or discomfort on or before 06/03/2016. Follow-up was completed as indicated.</p> <p>Center residents pain flow sheets were reviewed for documentation of pain assessment and efficacy on or before 06/03/2016. Follow-up comprehensive assessment and physician notification were completed as indicated by 06/17/2016.</p> <p>Center residents will have a comprehensive pain assessment completed by the Director of Nursing or Designee on or before 06/03/2016. The results of those assessments will be reviewed by the Director of Nursing or designee for needed modification to the resident's plan of care, or physician notification. Follow up will be completed on or before 06/17/2016.</p>		

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F 309	<p>Continued From page 13</p> <p>physician's orders and care plan which required the use a leg strap, to secure her catheter tubing and prevent tension and tugging at the catheter insertion site and to prevent potential irritation of the urethra and urinary meatus.</p> <p>2. Resident #8 was admitted to the facility with multiple diagnoses, including hypertension and coronary heart disease. Resident #8's 10/6/15 Physician Order documented the use of TED hose every morning. It further stated the TED hose were to be removed at bed time. Resident #8's 4/4/16 quarterly MDS assessment documented she was cognitively intact and required extensive staff assistance with dressing. Resident #8's care plan dated, 12/17/15, documented, "TED hose on in the morning and off at bed time " . Resident #8 did not have TED hose on her legs when observed on 4/25/16, 4/26/16, and 4/27/16, at 8:30 am, 10:30 am, and 3:45 pm, each day. On 4/27/16 at 8:00 am, Resident #8 said staff sometimes forgot to place the TED hose on her legs. Resident #8 said staff did not place the TED hose on her legs on 4/25/16, 4/26/16, and 4/27/16. On 4/27/16 at 3:50 pm, UM #12 said Resident #8 did not have TED hose on her legs per the physician order.</p> <p>3. Resident #25 was admitted to the facility on 11/2/15 with multiple diagnoses including a left hip fracture.</p> <p>Resident #25's physician's Order Summary Report documented Imitrex 100 mg 1 tablet every 24 hours as needed for migraines at onset</p>	F 309	<p>Current residents' pain care plans were reviewed by the Director of Nursing or Designee on or before 06/03/2016 to ensure that residents' potential for pain or discomfort, individualized pain goal, and resident specific interventions are identified.</p> <p>Residents with orders for TED hose were reviewed by the unit manager to ensure that Ted hose are applied per physician order on or before 05/30/2016. Follow-up and Ted hose applied as indicated.</p> <p>System Changes/Education: A pain management process monitor was completed by the Regional Nurse Consultant on or before 06/03/2016. Follow-up to be completed as indicated.</p> <p>Staff were re-educated on the stop and watch system for identifying/communicating change in resident condition on or before 06/03/2016. Upon the completion of this re-education, the stop and watch tool will be reviewed by the IDT in the morning clinical meeting to ensure that changes of condition have been timely addressed by the licensed nurse, and any additional follow-up is completed.</p> <p>Beginning the week of 05/30/2016 the Unit Manager or Designee will review the pain flow sheets for any persistent/unresolved pain as well as efficacy of medication.</p>		

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F 309	<p>Continued From page 14 of migraine.</p> <p>A Progress Note, dated 11/5/15 at 11:17 am, stated, "Awoke with migraine this am." The DON documented, "Meds for his headache unavailable in pyxis, attempted to get from Omniview, also not available there. Med with Norco for headache with little help. Given an Imitrex that his wife brought from home. Later I found the Imitrex in the cart in side drawer...good response to Imitrex, able to participate with therapy thereafter."</p> <p>During an interview on 4/28/16 at 1:42 pm, the DON stated the medication may have been misplaced. The DON stated the nurse should have called the physician or pharmacy if the medication was not located, and should have documented the contact in the nursing note. The DON confirmed that, even though present, the drug would be unavailable if the nurse was unable to locate it.</p>	F 309	<p>Follow-up resident assessment/intervention will be completed by the Director of Nursing or Designee on or before 06/17/2016.</p> <p>Licensed staffs were re-educated on-pharmacological pain interventions by the Geropsychiatrist on or before 06/17/2016.</p> <p>Licensed staff were re-educated on pain management including pain assessment, interventions, reassessment, and documentation requirements by the Director of Nursing or Designee on or before 06/03/2016.</p> <p>Licensed staff will be re-educated on following physicians orders by the Director of Nursing or Designee on or before 06/03/2016.</p> <p>Center quality of life rounds will be implemented beginning the week of 05/30/2016 to validate that care planned interventions and physicians orders such as ted hose are implemented at the bedside.</p> <p>Monitoring: Beginning the week of 05/30/2016 the Director of Nursing or Designee will audit 5 random residents to ensure that pain is managed with prn pain medication and non-pharmacological interventions implemented timely. Additionally the Director of Nursing or designee will audit</p>		

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F 309	Continued From page 15	F 309	5 resident records to ensure that pain assessments are completely documented including the completion of prn flow sheets. The Director of Nursing or designee will audit 5 random residents to ensure that physicians orders are followed and interventions are implemented at the bedside, including ted hose. These audits will be completed weekly X4 weeks and then monthly X2 months. The Director of Nursing will compile the results of these audits and report them to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Director of Nursing is responsible for monitoring and oversight.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		6/17/16	

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F 441	<p>Continued From page 16</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy and record review, and resident and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 4 (#13) residents sampled for catheter care. Failure to follow standard infection control measures placed the resident at risk for infections. Findings include:</p> <p>The facility's care of indwelling catheter policy and procedure, revised 2/16/16, documented "10. Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor."</p>	F 441	<p>Residents' Affected: Resident #13 was assessed for any signs or symptoms of infection by the LN Unit Manager on 05/20/2016 with none noted. Potential Residents' Affected: Center rounds were completed by the Administrator and Director of Nursing to ensure that infection control measures were followed including catheter bags not touching the floor, on 05/24/2016 follow up was completed as indicated. System Change/Education: Center staff will be re-educated by the Director of Nursing or Designee on infection control measures for ensuring</p>		

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F 441	Continued From page 17 Resident #13 was admitted to the facility with diagnoses including enlarged prostate and hernia repair. His 4/14/16 catheter care plan documented Resident #13's catheter tubing was to be kept off the floor. On 4/27/16 at 10:10 am, Resident #13 was sitting in his wheelchair in his room and the door to his room was open. The catheter tubing was in direct contact with the floor. The heels of his shoes also came in contact with the tubing that was under his wheelchair in direct contact with the floor. Resident #13 said staff had helped him with the catheter tubing and catheter bag. A few minutes later at 10:18 am, UM #19 adjusted the catheter tubing and confirmed the catheter tubing should not be in contact with the floor.	F 441	catheter tubing & bags do not touch the floor, on or before 06/03/2016. Beginning the week of 05/30/2016 weekly Quality of Life rounds will be implemented by the Administrator to ensure catheter bags are not on the floor. Education will be provided immediately for any identified issues. Monitoring: Beginning the week of 05/30/2016, Center dignity audit/ rounds will be completed by the Administrator or Designee of 3 residents to ensure that catheter bags and/or tubing do not touch floor. These audits will be completed weekly X4 weeks and then monthly X2 months or until resolved. The Administrator will compile the results of these audits and report them to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.		
F 517 SS=F	483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility disaster manual and elopement book, and staff interviews, it was determined the facility failed to ensure its emergency preparedness plan was	F 517	Residents' Affected: No residents identified. Potential Residents' Affected: A review of residents requiring a wander	6/17/16	

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F 517	<p>Continued From page 18</p> <p>complete and a complete missing resident procedure was readily available to staff. The deficient practice had the potential to affect all residents in the facility and could harm residents if staff were not able to evacuate residents in case of an emergency and/or assist in finding a missing resident. Findings include:</p> <p>Page 24 of the facility disaster manual documented, "Attachment 1 EVACUATION PLAN, Instructions: Place location specific evacuation plan and routes in this section. Be sure that the plan incorporates a procedure to account for all residents/patients (resident/patient identification system, e.g. bracelet, tags, etc.) and employees after the emergency evacuation has been completed such as mustering point and roll call." Page 24 in the evacuation section of the disaster manual did not contain the facility's specific evacuation plan and routes. It did not contain the facility specific procedure for identification of residents, or employees responsible after the evacuation has been completed and did not document a designated location to gather or assemble.</p> <p>Page 29 of the facility disaster manual documented, "Guideline A Fire Plan-Instructions: Place location specific fire plan in the section, include a facility map with a legend that denotes the pull stations, fire extinguishers and evacuation plan." Page 29 in the fire plan section of the disaster manual did not contain a facility map denoting the pull stations, fire extinguishers or evacuation plan.</p> <p>Page 41 of the facility disaster manual documented, "Guideline H, MISSING</p>	F 517	<p>guard was completed by Director of Nurses or Designee on or before 05/30/2016 and care plans were updated as needed.</p> <p>System Change/Education: Center staff will be re-educated by Director of Nursing or Administrator on Emergency Preparedness including but not limited to what to do if a resident is missing and evacuation procedures on or before 06/03/2016. An elopement binder will be placed at each nursing station with the center-specific policy for elopements and resident identifiers for those found to be at risk. Staff will be educated on system changes and processes related to elopements by the Director of Nursing or Designee on or before 06/17/2016. Center Staff will be re-educated on the process of checking wander guards daily to insure proper function by the Director of Nursing or Designee on or before 06/03/2016. A facility map with a legend that denotes fire pull stations, fire extinguishers, evacuation routes, mustering areas will be added to the Emergency Preparedness Binder by Administrator on or before 06/17/2016. Monitoring: Beginning the week of 05/30/2016, a center staff audit will be conducted by Administrator or Designee to insure all center staff know and follow the center-specific elopement policy. These audits will be completed weekly X4 weeks and then monthly X2 months or until resolved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2016
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	
F 517	<p>Continued From page 19</p> <p>RESIDENT/PATIENT, Instructions: Refer to Centers' Administrative Policies and Procedures, Elopement of Resident policy. Revise or replace with facility's process." Page 41 in the missing resident section did not contain facility specific guidelines for the missing resident process.</p> <p>Four of 4 disaster manuals placed at the facility's nurses' stations were observed and none of the disaster manuals had facility specific guidelines.</p> <p>Four of 4 Elopement policy and procedure manuals for a missing resident did not contain pages 2 and 3. The bottom of page 1 of the policy documented, "Witnessed Elopement: 2.1 Staff witnessing a confused patient or an identified elopement risk patient attempting to leave the center will intervene as appropriate to redirect the patient to a safe are and prevent elopement." The elopement book contained information related to 6 residents. Included in the book were face sheets with resident photographs and elopement evaluations. Review of a resident list documented that 7 residents had been identified as elopement risk and had physician orders' for a wander-guard bracelet. The elopement book did not contain information for all residents in the facility who had been identified as an elopement risk.</p> <p>On 4/26/16 at 2:45 pm, the Administrator said the facility had not included facility specific guidelines to the disaster manual and had not tailored the emergency procedures to the facility.</p> <p>On 4/26/16 at 3:30 pm, the DON said pages 2 and 3 of the elopement book were missing and he would replace those pages.</p>	F 517	The Administrator will compile the results of these audits and report them to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up		

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F 517	Continued From page 20	F 517			
F 518 SS=E	<p>On 4/26/16 pages 2 and 3 which were added to the elopement book, included: Unwitnessed Elopement, Guidelines for reporting, Follow-up guidelines, Documentation/Investigation and Quality Assurance Performance Improvement procedures.</p> <p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to ensure staff was knowledgeable of emergency procedures in the event of a fire, evacuation, or a missing resident event. This was true for 5 of 6 (CNA #s 13, 15, 16, LN#s 7 & 14) staff interviewed for emergency preparedness. The deficient practice had the potential to affect most residents in the facility. Findings included: On 4/26/16 at 3:45 pm, CNA #13 did not know the facility evacuation routes, employee assignments, or where staff gathered in an emergency and did not know how to use a fire extinguisher. On 4/26/16 at 3:50 pm, LN #7 was asked about what an emergency code color meant and she said, "I think you announce code orange but I</p>	F 518	<p>Residents' Affected: No residents identified. Potential Residents' Affected: The Administrator will meet with the Resident Council to advise members about the evacuation policy and procedures on 06/16/2016. Any concerns were noted and pertinent changes were updated in the Emergency Preparedness Binder; Evacuation Procedures. Resident family members, POA, or Guardians will be notified by letter from the Center to inform about evacuation changes and locations on or before 06/17/2016. System Change/Education: The Emergency Preparedness Manual will be updated by the Administrator, on or before 06/17/2016. Evacuation locations,</p>	6/17/16	

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F 518	<p>Continued From page 21</p> <p>need to look at the disaster manual to find out what to do." LN #7 obtained the disaster manual from the nurses' station and reviewed the index. LN #7 turned to a section of the manual and said, "This doesn't really tell you what to do." LN #7 did not know how to account for all residents on the unit or the evacuation route and did not know what to do if the fire alarm goes off, or how to use a fire extinguisher. LN #7 did not know to announce a missing resident's name over the intercom in the event of a suspected elopement.</p> <p>On 4/26/16 at 4:15 pm, LN #14 did not know to announce a missing resident's name over the intercom.</p> <p>On 4/27/16 at 9:10 am, CNA #15 did not know what to do if the fire alarm went off, the evacuation route, or where the fire extinguisher was located on the unit or how to use a fire extinguisher.</p> <p>On 4/27/16 at 3:00 pm, CNA #16 did not know what to do when the fire alarm goes off, the evacuation route, how to account for residents during an emergency, or how to use a fire extinguisher.</p>	F 518	<p>routes, directions, mustering areas, responsibilities and procedures were added in detail for all Center staff. Center Staff will be re-educated by the Administrator or Designee on or before 06/03/2016 on emergency procedures, evacuation routes, mustering areas, fire procedures, elopement procedures, emergency codes, and where to find these procedures in the Emergency Preparedness Manual.</p> <p>An evacuation drill will be conducted by Administrator or Designee on or before 06/17/2016 to educate and train staff on procedures for evacuation.</p> <p>Center Staff will be re-educated by Administrator or Designee on or before 06/17/2016 on use of fire extinguishers. All Center Staff will be provided cards to attach to the back of their name badge indicating Emergency Code Colors and each color code meaning on or before 06/17/2016.</p> <p>Monitoring: Beginning the week of 05/30/2016 a Center staff audit will be conducted by the Administrator or Designee to insure all center staff know and follow the center-specific evacuation, fire, and emergency policies. These audits will be completed weekly X4 weeks and then monthly X2 months or until resolved. The Administrator will compile the results of these audits and report them to the QAPI committee for review monthly X3 months or until substantial compliance is achieved. The Administrator is responsible for monitoring and follow-up.</p>		

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

PRINTED: 11/30/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2016
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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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 19, 2016

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

Provider #: 135125

Dear Mr. Strong:

On **April 29, 2016**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006807

Several residents were observed for toenail care.

The identified resident's medical record and 12 other residents' records were reviewed.

The Director of Nursing was interviewed.

Allegation: The Reporting Party said an identified resident did not receive appropriate toe nail care and/or podiatry services.

Findings: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from April 25, 2016 to April 29, 2016.

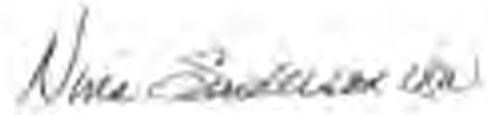
This allegation was received in December of 2014. The facility had a survey in September of 2014, and was found to be out of compliance at F 328, Specialty Care, which includes podiatry care. The allegation was substantiated for this resident, but no new deficiencies were cited as the facility had already been cited, submitted a plan of correction, and was found to be in substantial compliance for Specialty Care prior to the April 2016 survey.

Richard Strong, Administrator
May 19, 2016
Page 2 of 2

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in dark ink, appearing to read "Nina Sanderson". The signature is written in a cursive style and is positioned above the typed name.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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August 24, 2016

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

Provider #: 135125

Dear Mr. Strong:

On **April 29, 2016**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007132

The complaint was investigated in conjunction with the facility's on-site recertification and state licensure survey conducted from April 25, 2016 to April 29, 2016.

The identified resident and twenty-four other residents' medical records were reviewed. The facility's grievance files from January 1, 2015 to April 25, 2016 were reviewed. Resident council meeting minutes from February to April 2016 were reviewed.

The identified resident's medical record did not include any concerns related to food variety, tough meats, condiments, and bedtimes snacks.

The facility's grievances did not include any grievances related to the facility not serving vegetables with meals.

The resident council meeting minutes did not include concerns related to the facility not serving vegetables with meals.

Several residents in the Group Interview, five individual residents, and two family members were interviewed regarding Quality of Care, Quality of Life, Dietary Services, and Physical Environment. Several staff including CNAs, the Dietary Manager, the assistant Dietary Manager, and a prep cook were interviewed.

Allegation #1: The reporting party said the facility does not serve vegetables with meals.

Findings #1: During the survey process the preparation and distribution of meals and snacks was observed and the facility's menus were reviewed. The menus included a wide variety of vegetables.

The residents and family members interviewed and the residents who attended the Group Interview did not voice any concerns regarding the menus, the foods and vegetables served, or the lack of any foods served, such as vegetables.

Two test trays were evaluated for food temperature, food variety, and palatability. The test tray results were palatable food temperature and variety.

Based on observations, review of the facility's grievances and Resident Council meeting minutes, test tray evaluations, and resident and family interviews, it was determined the allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The reporting party stated the menus did not have variety, with too much white bread, potatoes, and rice; and meats were tough.

Findings #2: During the survey process the facility's menu cycle and menus were reviewed. The menus included a wide variety of different types of breads and potatoes, vegetables, and main dishes.

The facility's grievances did not include any grievances related to menu variety or tough meats.

The Resident Council meeting minutes did not include concerns related to menu variety or tough meats.

The residents and family members interviewed and the residents who attended the Group Interview did not voice any concerns regarding menu variety or that too much white bread, potatoes, and rice were served or the meats served were tough.

Two test trays were evaluated for food temperature, food variety, and palatability. The test tray results were palatable food temperature and variety.

Based on observations, review of the facility's grievances and Resident Council meeting minutes, review of the facility's menus, test tray evaluations, and resident and family interviews, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The reporting party said the food that was already served would be cold by the time the Certified Nurse Aides (CNAs) filled the condiment holders.

Findings #3: Several meals were observed during the survey process. In the dining rooms, condiments were available on each of the tables. For those residents who dined in their rooms, condiments were included on their trays as allowed by any dietary restrictions.

During the meal observations, the CNAs were not observed to leave the dining room to fill condiment holders and later return the condiment holders to the dining rooms.

The facility's grievances did not include any grievances related to the residents' foods becoming cold by the time the CNAs filled the condiment holders.

The resident council meeting minutes did not include concerns related to the residents' foods becoming cold by the time the CNAs filled the condiment holders.

The residents and family members interviewed and the residents who attended the Group Interview did not voice any concerns regarding the condiments in the dining rooms or on the residents' room trays.

Based on observations, review of the facility's grievances and Resident Council meeting minutes, and resident and family interviews, it was determined the allegation could not be substantiated.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The reporting party said the facility's bedtime snacks were not substantial for residents with hypoglycemia.

Findings #4: The preparation and distribution of bedtime snacks was observed.

The prep cook prepared 4-ounce servings of jello, pudding, and canned fruits in plastic cups covered with a lid, and peanut butter and jelly and roast beef sandwiches.

After preparing the sandwiches, the prep cook cut the sandwiches in half and wrapped each half with plastic wrap. The snacks were then distributed and placed in the refrigerators located on each wing of the facility.

The prep cook was interviewed and said snacks were served three times a day, in the morning, in the afternoon, and before residents went to bed. The Dietary Manager was interviewed and said the snack serving sizes were based on heart healthy and diabetic diets.

Five CNAs who worked the evening shift were interviewed. The CNAs stated all the residents were offered a bedtime snack. In addition, the CNAs said in the event a resident who was diagnosed with diabetes asked for an additional bedtime snack, the CNAs would check with the nurse on duty prior to obtaining an additional snack for that specific resident.

The facility's grievances did not include any grievances related to bedtime snacks for residents.

The Resident Council meeting minutes did not include any concerns related to bedtime snacks for residents.

The residents and family members interviewed and the residents who attended the Group Interview did not voice any concerns regarding the bedtime snacks provided by the facility.

Based on observations, review of the facility's grievances and Resident Council meeting minutes, and resident and family members interviews, the allegation could not be substantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: The reporting party said the facility provided a resident with a worn mattress.

Findings #5: The identified resident's medical record did not include any concerns related to a worn and uncomfortable mattress.

Observations conducted throughout the survey process did not reveal residents were provided with worn and uncomfortable mattresses.

The facility's grievances did not include any grievances related to a resident receiving a worn and uncomfortable mattress.

The resident council meeting minutes did not include concerns related to residents receiving worn and uncomfortable mattresses.

Richard Strong, Administrator
August 24, 2016
Page 5 of 5

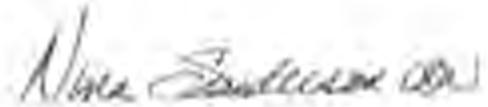
The residents and family members interviewed and the residents who attended the Group Interview did not voice any concerns regarding worn and uncomfortable mattresses.

Based on observations, review of the facility's grievances and resident council meeting minutes, and resident and family members interviews, the allegation could not be substantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script, appearing to read "Nina Sanderson".

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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E-mail: fsb@dhw.idaho.gov

July 25, 2016

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

Provider #: 135125

Dear Mr. Strong:

On **April 29, 2016**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007150

Medication pass was observed during the survey. Seventeen residents were observed for hygiene care. Three residents were observed for pressure ulcers and skin issues. Seventeen residents' rooms were observed for cleanliness.

The identified resident's medical record, along with twenty-one additional residents' records, were reviewed. The facility's 2015 and 2016 Grievance files were reviewed. Resident Council minutes from February to April 2016 were reviewed. The facility's Incident and Accident reports from November 2015 to April 2016 were reviewed.

Five individual residents and two family interviews were conducted, along with a resident group interview. Multiple staff, including licensed nurses, CNAs, and the Director of Nursing were interviewed.

Allegation #1: The Reporting Party said an identified resident had knee pain which was not addressed.

Findings #1: The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from April 25, 2016 to April 29, 2016.

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on observation, record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F309.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: An identified resident did not receive appropriate treatment for a blood clotting condition.

Findings #2: The identified resident's clinical record and twelve other residents' records were reviewed for lab work and physician notification and no concerns were identified.

The Director of Nursing said lab results were sent to physicians to review and write orders based on the results.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: An identified resident could not reach his/her call light and staff did not respond quickly enough after the resident fell.

Findings #3: Based on observation, and resident and staff interviews, it was determined the allegation was substantiated and cited at F246.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #4: An identified resident did not receive appropriate treatment for a skin tear which was caked with dried blood.

Findings #4: The identified resident's clinical record and three other residents' records were reviewed for skin issues and no concerns were identified. The facility's Incident and Accidents reports from November 2015 to April 2016 were reviewed and no there were no concerns regarding treatment of skin tears.

A wound care nurse and the Director of Nursing said all skin issues are treated according to physician orders.

Based on record review and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: An identified resident's physician was not informed of a need for a knee x-ray and a worsening of the resident's edema.

Findings #5: The identified resident's clinical record and seventeen other residents' records were reviewed and there were no concerns regarding physician notifications.

Several nurses said physicians are informed whenever there is a change of condition for residents.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: An identified resident was transported to an off-site appointment in an unsafe manner by a city taxi and without staff assistance.

Findings #6: The identified resident's clinical record was reviewed and no concerns were identified. The billing records of a transportation service was reviewed and no concerns were identified.

The Administrator said the identified resident was not sent to the appointment via city taxi, but a shuttle service which provides assistance to persons who are medically compromised and the service provided appropriate assistance for the resident.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #6: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: The facility was filthy, floors were not cleaned, trash was not emptied, and bed linens were not changed.

Findings #7: Seventeen residents' rooms were observed for cleanliness and no concerns were identified.

Resident Council minutes from February to April 2016 did not indicate cleanliness was a concern.

Five individual residents, two family members and several residents in the group interview said cleanliness was not a concern. One housekeeper said residents' rooms were cleaned daily.

Based on observations, record review, resident, family and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #7: Unsubstantiated. Lack of sufficient evidence.

Allegation #8: The identified resident was not bathed frequently enough and had body odor.

Findings #8: Seventeen residents were observed for cleanliness and body odor and no concerns were identified.

The identified resident's clinical record and five other residents' records were reviewed for bathing frequency and no concerns were identified.

Five individual, two family members and several residents in the group interview did not indicate bathing or body odor was a concern. Several CNAs were interviewed and they said residents received showers based on their care plans and their preferences.

Based on observation, record review, resident, family and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #8: Unsubstantiated. Lack of sufficient evidence.

Allegation #9: An identified resident developed blisters and sores on his/her feet and toes.

Findings #9: Three residents were observed for pressure ulcers and skin issues and no concerns were identified.

The identified resident's clinical record and three other residents' records were reviewed for pressure ulcers and skin issues and no concerns were identified. The facility's Incident and Accident reports from November 2015 to April 2016 were reviewed and no concerns were identified regarding pressure ulcers and skin issues.

The Director of Nursing said residents receive skin checks upon admission and throughout their stay and any issues identified are treated appropriately.

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #9: Unsubstantiated. Lack of sufficient evidence.

Richard Strong, Administrator
July 25, 2016
Page 5 of 5

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

DAVID SCOTT, RN, Supervisor
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

May 29, 2018

Cindy Jerow
12678 West Audi Court
Boise, ID 83713

Dear Ms. Jerow:

Please accept my apology for the extreme tardiness of this response. On **April 29, 2016**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007150

Medication pass was observed during the survey. Seventeen residents were observed for hygiene care. Three residents were observed for pressure ulcers and skin issues. Seventeen residents' rooms were observed for cleanliness.

The identified resident's medical record, along with twenty-one additional residents' records, were reviewed. The facility's 2015 and 2016 Grievance files were reviewed. Resident Council minutes from February to April 2016 were reviewed. The facility's Incident and Accident reports from November 2015 to April 2016 were reviewed.

Five individual residents and two family interviews were conducted, along with a resident group interview. Multiple staff, including licensed nurses, CNAs, and the Director of Nursing were interviewed.

Allegation #1:

The Reporting Party said an identified resident had knee pain which was not addressed.

Findings #1:

The complaint was investigated in conjunction with the facility's on-site Recertification survey conducted from April 25, 2016 to April 29, 2016.

The identified resident was no longer residing in the facility at the time the complaint was investigated.

Based on observation, record review and staff interview, it was determined the allegation was substantiated and the facility was cited at F309.

Conclusion #1:

Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2:

An identified resident did not receive appropriate treatment for a blood clotting condition.

Findings #2:

The identified resident's clinical record and twelve other residents' records were reviewed for lab work and physician notification and no concerns were identified.

The Director of Nursing said lab results were sent to physicians to review and write orders based on the results.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #2:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

An identified resident could not reach his/her call light and staff did not respond quickly enough after the resident fell.

Findings #3:

Based on observation, and resident and staff interviews, it was determined the allegation was substantiated and cited at F246.

Conclusion #3: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #4:

An identified resident did not receive appropriate treatment for a skin tear which was caked with dried blood.

Findings #4:

The identified resident's clinical record and three other residents' records were reviewed for skin issues and no concerns were identified. The facility's Incident and Accidents reports from November 2015 to April 2016 were reviewed and there were no concerns regarding treatment of skin tears.

A wound care nurse and the Director of Nursing said all skin issues are treated according to physician orders.

Based on record review and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #4:

Unsubstantiated. Lack of sufficient evidence.

Allegation #5:

An identified resident's physician was not informed of a need for a knee x-ray and a worsening of the resident's edema.

Findings #5:

The identified resident's clinical record and seventeen other residents' records were reviewed and there were no concerns regarding physician notifications.

Several nurses said physicians are informed whenever there is a change of condition for residents.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #5:

Unsubstantiated. Lack of sufficient evidence.

Allegation #6:

An identified resident was transported to an off-site appointment in an unsafe manner by a city taxi and without staff assistance.

Findings #6:

The identified resident's clinical record was reviewed and no concerns were identified. The billing records of a transportation service was reviewed and no concerns were identified.

The Administrator said the identified resident was not sent to the appointment via city taxi, but a shuttle service which provides assistance to persons who are medically compromised and the service provided appropriate assistance for the resident.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #6:

Unsubstantiated. Lack of sufficient evidence.

Allegation #7:

The facility was filthy, floors were not cleaned, trash was not emptied, and bed linens were not changed.

Findings #7:

Seventeen residents' rooms were observed for cleanliness and no concerns were identified.

Resident Council minutes from February to April 2016 did not indicate cleanliness was a concern.

Five individual residents, two family members and several residents in the group interview said cleanliness was not a concern. One housekeeper said residents' rooms were cleaned daily.

Based on observations, record review, resident, family and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #7:

Unsubstantiated. Lack of sufficient evidence.

Allegation #8:

The identified resident was not bathed frequently enough and had body odor.

Findings #8:

Seventeen residents were observed for cleanliness and body odor and no concerns were identified.

The identified resident's clinical record and five other residents' records were reviewed for bathing frequency and no concerns were identified.

Five individuals, two family members and several residents in the group interview did not indicate bathing or body odor was a concern. Several CNAs were interviewed and they said residents received showers based on their care plans and their preferences.

Based on observation, record review, resident, family and staff interviews, it was determined the allegation could not be substantiated.

Conclusion #8:

Unsubstantiated. Lack of sufficient evidence.

Allegation #9:

An identified resident developed blisters and sores on his/her feet and toes.

Findings #9:

Three residents were observed for pressure ulcers and skin issues and no concerns were identified.

The identified resident's clinical record and three other residents' records were reviewed for pressure ulcers and skin issues and no concerns were identified. The facility's Incident and Accident reports from November 2015 to April 2016 were reviewed and no concerns were identified regarding pressure ulcers and skin issues.

The Director of Nursing said residents receive skin checks upon admission and throughout their stay and any issues identified are treated appropriately.

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

Conclusion #9:

Unsubstantiated. Lack of sufficient evidence.

Even though incidents or events may have occurred as you described them, it is not always possible to find evidence that corroborates or substantiates each allegation in the complaint. When the allegation is referred to as unsubstantiated, it means that non-compliance with a regulation could not be proven. It does not mean that an incident did not occur or that a family member or visitor did not witness a problem. It means that an allegation could not be confirmed through the investigation process or the facility took corrective measures prior to the investigation.

Cindy Jerow
May 29, 2018
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Based on the findings of the investigation, the facility was required to submit a Plan of Correction in writing to this office. In the facility's Plan of Correction, they stated the actions taken to correct each deficiency and a date it would be completed. A copy of the survey results may be obtained, after the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards has released it for public disclosure, through the Internet at www.facilitystandards.idaho.gov, posted under survey results, or through a Public Records Request. The contact information for making a Public Records Request is at www.healthandwelfare.idaho.gov/AboutUs/PublicRecordsRequest, or you may call (208) 334-5564 or the fax number is (208) 334-6558. The Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards will continue to monitor the progress of the facility.

Thank you for bringing these concerns to our attention. If you have any questions, comments or concerns, or if we can assist you further, please contact Debby Ransom, RN, RHIT, at (208)334-6626, option 5.

Sincerely,

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSSELL S. BARRON– Director

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June 5, 2018

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

Provider #: 135125

Dear Mr. Strong:

On **April 29, 2016**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from April 25, 2016 to April 29, 2016.

Facility room phones were observed. Medication pass was observed. Residents were observed for over sedation and delay in treatment.

The identified resident's medical record was reviewed. Twenty-five other residents' medical records were reviewed. Grievances from January 2015 to April 2016 were reviewed. Resident Council minutes from February to April 2016 were reviewed.

Five individual residents and two family members were interviewed. Several residents in the Group meeting were interviewed. Several nurses, Certified Nursing Assistants, the Business Office Manager, Director of Maintenance, Admissions Coordinator, and a Social Worker were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007048

ALLEGATION #1:

Residents are not given adequate notice that their Skilled Nursing Medicare benefit is ending.

FINDINGS #1:

Richard Strong, Administrator
June 5, 2018
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The identified resident was no longer residing in the facility at the time the complaint was investigated.

An Advanced Beneficiary Notice form from the facility to the identified resident documented the resident's Medicare coverage would end on 6/4/15. However, the form did not include a reason for the coverage termination and it was not signed by the resident to indicate receipt.

On 4/26/16 at 11:00 am, the Business Office Manager said she was not sure why the identified resident's Medicare coverage ended because the reason was not on the form. The Business Office Manager also indicated the form was not signed by resident to acknowledge the resident received the information.

It was determined the facility failed to ensure the identified resident was provided advance notice of their right to appeal the termination of coverage for the stay in the facility. The allegation was substantiated and a deficiency was cited at F156.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

Discharge planning is not provided and residents and family members are not given advance notice of discharge.

FINDINGS #2:

The identified resident's medical record was reviewed and did not document concerns with discharge planning. Seven other resident's records were reviewed for discharge issues and none were identified.

A Social Worker said discharge planning started as soon as a resident is admitted to the facility. The Social Worker said work with residents and families increase the closer the anticipated discharge date approaches.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents' room phone do not work, making it difficult for family members to maintain contact.

FINDINGS #3:

Several residents' room phones were observed to work. The identified resident's record did not document a concern with the resident's room phone. Grievances and Resident Council minutes were reviewed and did not include concerns with room phones.

The residents in the Group Interview said there were no phone concerns. A Unit Manager said the room phones worked. The Admissions Coordinator said when residents were admitted they were given the phone number for their room so they could share the number with their friends and family. The Director of Maintenance said work order forms are at each nurses station so staff can report issues to be fixed.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' medications are given late or not at all.

FINDINGS #4:

The identified resident's record was reviewed, staff and residents were interviewed, and medication administration was observed for timeliness and correct medication administration procedures.

The identified resident's record documented medications were given appropriately and on time. Concerns were, however, identified for another resident. The other resident awoke with a migraine headache and the medication ordered by the physician was not found in the facility. To treat the resident's migraine, a family member brought the ordered medication from home.

Based on the findings related to the other resident, it was determined the allegation was substantiated and the facility was cited at F309, as it relates to the failure of the facility to ensure each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

Residents receiving pain medications are over-sedated.

FINDINGS #5:

Richard Strong, Administrator
June 5, 2018
Page 4 of 4

Eleven residents were observed for pain medication over-sedation and no concerns were identified. Medication pass was observed and no concerns related to over-sedation were noted.

The identified resident's medical record and 11 other residents' records did not document a concern regarding over-sedation.

Five residents and two family members were interviewed and did not express concerns of over-sedation. Several nurses were interviewed and said they watched for any signs and symptoms of over-sedation and would not administer more medication than what was ordered by the physician.

Based on the investigative findings, it was determined the allegation could not be substantiated.

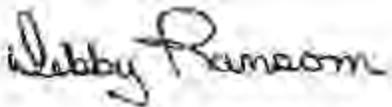
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Debby Ransom, RN, RHIT at (208) 334-6626, option 5. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, flowing style.

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj