



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF 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

February 14, 2017

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

Provider #: 135125

Dear Mr. Strong:

On February 9, 2017, an on-site revisit of your facility was conducted to verify correction of deficiencies noted during the survey of December 16, 2016. Meridian Center Genesis Healthcare was found to be in substantial compliance with federal health care requirements regulations as of January 11, 2017.

Thank you for the courtesies extended to us during our on-site revisit. 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,

David Scott, R.N., Supervisor
Long Term Care

DS/lj



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

June 15, 2017

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

Provider #: 135125

Dear Mr. Strong:

On **February 9, 2017**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. This complaint was investigated at the facility on February 9, 2017. The clinical record of the identified resident and five other residents were reviewed for incidents and accidents, use of antibiotics, staff following physician orders and care plans. The facility's staffing levels were reviewed and staff response times to resident call lights were observed throughout the investigation. The facility's Administrator and Director of Nursing were interviewed regarding quality-of-care and quality-of-life concerns, as well as the specific allegations of this complaint.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007402

ALLEGATION #1:

The Reporting stated an identified resident fell from bed when his/her legs became entangled in the sheets while he/she was reaching for the call light. A fall mat was in the room, but not in use, at the time of the incident.

FINDINGS #1:

The identified resident was admitted to the facility in October 2016 with diagnosis of repeated falls, aftercare following surgical joint replacement, dizziness, difficulty walking, weakness, history of traumatic brain injury, and sleep apnea.

An Incident and Accident Report documented the identified resident was heard calling for help at 6:45 am on October 24, 2016. Staff responding to the call for help found the resident with his/her knees on a fall mat and his/her torso still on the bed. The resident denied any pain related to the incident, but was assessed for injury after being repositioned back in bed. The Report documented the resident's bed alarm was turned off and that this was because the resident slept on his/her stomach, which unintentionally triggered the alarm. The identified resident could not explain why he/she was attempting to get out of bed at the time of the incident. The resident's physician was notified of the incident at 9:30 am, and the family was notified at 11 am. Vital signs and neurological checks were completed following the fall. The

Random residents interviewed during the complaint investigation stated they did not have concerns regarding staff response time to call lights and there was no documented evidence in the clinical record that the identified resident fell while waiting for staff to respond to his/her call light. This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party stated facility staff failed to remove the staples from a surgical incision site per physician order. The identified resident's surgical wound became "swollen and red" and was painful. The facility eventually requested, received, and implemented a physician's order to remove the staples.

FINDINGS #2:

The clinical record documented a Nurse Practitioner visited the facility to assess the identified resident's surgical wound on October 25, 2016 following reports from staff that the resident "continues to pull dressing off and pick at the wound." A staff nurse was about to remove the surgical staples at noon that day, but the wound was "red" and photographs were instead sent to a Nurse Practitioner, who ordered a dressing for the wound to prevent the resident from "picking at it." Later that day, following a second assessment of the wound, the physician ordered an antibiotic. On October 27, 2016, the resident was noted to remove the wound dressing "on a

regular basis (twice a day minimum)," and the wound was documented as "red and warm to the touch." The resident was admitted to a hospital that day "to be opened back up to clean out the infection from the inside." The infection was attributed to the resident's repeated hand-to-wound contact, rather than the continued presence of surgical staples. This allegation was not substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party stated staff was "dismissive" when concerns regarding an identified resident were brought to the facility's attention.

FINDINGS #3:

A review of the facility's Grievance File and interviews with five random residents did not reveal any concerns of staff dismissiveness. There was no documentation in the identified resident's clinical record regarding inappropriate staff treatment of either the resident and/or his/her interested parties. This allegation could not be substantiated for lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The Reporting Party stated the facility failed to administer antibiotics as ordered by an identified resident's physician.

FINDINGS #4:

The identified resident's clinical record documented a physician ordered facility nursing staff to provide the resident with Levaquin 500 milligrams tablets daily for seven days, beginning October 25, 2016, related to "left hip surgical site infection." An Order Processing form documented the antibiotic was delivered to the facility and administered to the resident daily prior to his/her discharge to a hospital on October 27, 2016. This allegation was not substantiated for lack of evidence.

Richard Strong, Administrator
June 15, 2017
Page 4 of 4

CONCLUSIONS:

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 black ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a stylized "S".

David Scott, R.N., Supervisor
Long Term Care

DS/lj



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

June 15, 2017

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

Provider #: 135125

Dear Mr. Strong:

On **February 9, 2017**, an unannounced on-site investigation of an entity-reported incident was conducted at Meridian Center Genesis Healthcare. The entity-reported incidents, findings and conclusions are as follows:

Entity-Report Incident #ID00007448

ALLEGATION #1:

The Reporting Party stated the facility asked staff to falsify residents' clinical records, including those pertaining to skin checks, initial assessments, and pressure ulcers.

FINDINGS:

This allegation was investigated during an on-site complaint investigation on February 9, 2017. The clinical records of six residents were reviewed for evidence of false documentation. Documents reviewed included initial assessments, care plans, physicians' orders, skin assessments, Medication Administration Records, Treatment Administration Orders, Nurse- and Physician Progress Notes, Social Services Notes, Physical/Occupation/Speech Therapy Progress Notes, and wound treatment records. The allegation did not specify any resident by name nor provide a timeframe for when the alleged request to falsify records occurred. The facility's Grievance File did not include any concerns related to false documentation and interviews with the facility's Administrator and Director of Nursing, as well as with several floor nurses, failed to

Richard Strong, Administrator
June 15, 2017
Page 2 of 2

produce evidence that staff had been asked to falsify medical records. This allegation could not be substantiated due to a lack of evidence.

CONCLUSIONS:

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 black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor
Long Term Care

DS/lj