



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSSELL S. BARRON – 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](mailto:fsb@dhw.idaho.gov)

August 15, 2018

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

Provider #: 135125

Dear Mr. Strong:

On **July 26, 2018**, 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.) **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.

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 **August 25, 2018**. Failure to submit an acceptable PoC by **August 25, 2018**, may result in the imposition of civil monetary penalties by **September 17, 2018**.

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(ies):

### **Civil Money Penalty**

### **Denial of payment for new admissions effective October 26, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 26, 2019**, 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.**

Richard Strong, Administrator  
August 15, 2018  
Page 3 of 3

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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.

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/ta/bid/434/Default.aspx>

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

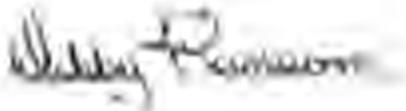
- BFS Letters (06/30/11)

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

This request must be received by **August 25, 2018**. If your request for informal dispute resolution is received after **August 25, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

DR/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE</b> <b>MERIDIAN, ID 83642</b>		
(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	INITIAL COMMENTS  The following deficiencies were cited during the complaint survey of the facility. The survey team entered the facility on July 23, 2018 and exited the facility on July 26, 2018.  The surveyors were:  Edith Cecil, RN Arnold Rosling, RN  Survey Abbreviations:  ADLs - Activities of daily living MDS - Minimum Data Set	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		9/12/18	

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

TITLE

(X6) DATE

Electronically Signed

08/24/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 550	<p>Continued From page 1</p> <p>provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and policy review, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 1 of 2 residents (#14) observed dining in the facility. This failure had the potential to cause a decrease in residents' sense of self-worth and psychosocial wellbeing. Findings include:  The facility's Meal Service in Dining Room policy, dated 6/1/96, directed staff to serve all residents at a table at the same time.  On 7/25/18 at 12:25 PM, Resident #14 was seated at a table with one other resident for</p>	F 550	<p>Residents Affected: Resident #14 was assessed by LSW for any related psycho-social affects related to meals not being served at the same time as those residents sitting at the same table on or before 08/31/2018. Any concerns will be followed up on as indicated.</p> <p>Potential Residents Affected: Resident interviews were conducted by LSW on or before 08/31/2018 of alert and oriented residents who eat their meals in the dining room for psycho-social issues related to meals not being served at the same time as other residents at the table. Any issues will be followed up on as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 550	<p>Continued From page 2</p> <p>lunch. Resident #14's tablemate had her meal plate in front of her and was seasoning her food with salt and pepper. Resident #14 had a coffee cup in front of her. At 12:30 PM, Resident #14 asked, "Why does it take so long to get my food?"</p> <p>On 7/25/18 at 12:40 PM, the Registered Dietitian reassured Resident #14 that her food would be to her shortly.</p> <p>On 7/25/18 at 12:50 PM, 25 minutes after her tablemate received her food, Resident #14's lunch was served to her. Resident #14's tablemate had finished her meal.</p> <p>On 7/25/18 at 1:30 PM, the Registered Dietitian stated residents seated at the same table should be served at the same time. She stated Resident #14's meal ticket was not with her tablemate's.</p>	F 550	<p>indicted.</p> <p>A dining review was completed for breakfast, lunch, and dinner on or before 08/31/2018 to identify if meals were being served on-time and to residents and the same time by the Center Executive Director (CED) or designee. Any identified concerns were immediately addressed by the CED or designee at the time of identification.</p> <p>Systematic Change/Education: Beginning the week of 09/03/2018, dining room signage will be changed to "Dining room opens at" to allow for residents individual choices coming in early and/or later to the meal service.</p> <p>Genesis Meridian Staff that assist in the dining room will be educated on or before 09/07/2018 on residents seated at the same table will have tickets turned in for service immediately.</p> <p>Dietary staff will be educated by the Director of Food Service on or before 09/07/2018 on meal service times and insuring resident seated at the same tables will be served together or as quickly as possible once the resident arrives in the dining room for meal service.</p> <p>Dining room monitors will be educated on or before 09/07/2018 on serving all residents seated at the same table at the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 550	Continued From page 3	F 550	<p>same time; or residents arriving late will be served as soon as possible. Dining room monitors will be required to assist in the dining room until the last tray is served.</p> <p>Monitors: Beginning the week of 09/10/2018, an audit of the dining room service will be conducted by the Center Executive Director or designee to insure residents sitting together will be served at the same time. These audits will be conducted weekly x4 weeks and then monthly x2 months.</p> <p>The results of these audits will be compiled and reported to the QAPI committee for review monthly for 3 months or until substantial compliance is maintained. The Center Executive Director is responsible for monitoring and follow-up.</p>		
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p>	F 656		9/12/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 656	<p>Continued From page 4</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident and staff interview, and policy review, it was determined the facility failed to ensure residents care plans addressed the frequency of baths/showers, the level of assistance required for them, or preferences the resident may have. This was true for 1 of 2 (#1) residents reviewed for bathing.</p>	F 656	<p>Residents Affected:</p> <p>Resident #1 Care Plan was revised with resident preferences for bathing, bathing assistance required, frequency of bathing, and bathing schedule on or before 08/31/2018.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 656	<p>Continued From page 5</p> <p>This failure created the potential for residents to receive baths less frequently than needed and/or desired and with less staff assistance than necessary to safely and thoroughly complete the task. Findings include:</p> <p>The facility's Person-Centered Care Plan policy, last revised 3/1/18, documented the care plan must describe the services to be furnished and show evidence of resident's goals and preferences.</p> <p>The facility's Activities of Daily Living (ADLs) policy, last revised 11/28/16, documented "Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services. ADLs include hygiene-bathing."</p> <p>Resident #1 was admitted to the facility on 1/3/18 with multiple diagnoses, including chronic interstitial cystitis (bladder pain and discomfort) and chronic nephritis (inflammation of the kidneys).</p> <p>Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 7/16/18, documented her cognition was severely impaired and she required extensive assistance from one person for most activities of daily living (ADLs.) The MDS assessment documented Resident #1 was not bathed during the 7 days prior to the assessment.</p> <p>A care plan problem, dated 1/4/18, documented Resident #1 required assistance/was dependent on staff for bathing. The care plan goal</p>	F 656	<p>Potential Residents Affected: A care plan audit was conducted on or before 09/07/2018 by the Center Nurse Executive (CNE) or designee to insure that all residents bathing preferences, assistance required, and bathing schedules; including frequency are consistent with resident choice and preferences. Any concerns or issues were addressed by the CNE or designee at the time of identification.</p> <p>Systematic Change/Education: Beginning the week of 09/03/2018, new admissions will be reviewed in morning clinical meeting by CNE or designee to insure care plans related to bathing, bathing assistance, bathing schedule and frequencies are consistent with resident preferences.</p> <p>Beginning the week of 09/03/2018, residents care plans will be reviewed by CNE or designee during quarterly care conferences, upon change of condition, or resident/family request for bathing, bathing assistance, and bathing schedule and frequency to insure bathing is consistent with resident preferences.</p> <p>Licensed Nurse staff will be educated by CNE or designee on or before 09/07/2018 on resident preferences and care plans related to bathing, bathing assistance,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 656	Continued From page 6 documented Resident #1 would improve her current level of function in bathing. The care plan did not provide interventions that identified assessed needs, goals, or Resident #1's preferences for bathing.  On 7/24/18 at 2:00 PM, Resident #1 stated she was scheduled for one shower per week. She stated the schedule for her showers had changed, first it was Thursdays, then it went to Fridays, then Mondays. Resident #1 stated when she was first admitted she received 2 showers a week. Resident #1 stated she needed more showers  On 7/25/18 at 3:00 PM, the Interim Director of Nursing reviewed Resident #1's care plan and stated he could not find assessed needs goals, or preferences.	F 656	and bathing schedule and frequency.  Monitors: Beginning the week of 09/10/2018, an audit of 10 resident care plans related to bathing, bathing assistance, bathing schedule and frequency are consistent with resident preferences and choice will be conducted by CNE or designee. These audits will be conducted weekly x4 weeks and then monthly x2 months.  Beginning the week of 09/10/2018, an audit of 10 resident ADL charting will be conducted by CNE or designee to insure bathing assistance, schedule, and frequency are consistent with resident care plan. These audits will be conducted weekly x4 weeks and then monthly x2 months.  The results of these audits will be complied and reported to the QAPI committee for review monthly for 3 months or until substantial compliance is maintained. The Center Nurse Executive is responsible for monitoring and follow-up.		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition,	F 677		9/12/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE</b> <b>MERIDIAN, ID 83642</b>		
(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 677	<p>Continued From page 7</p> <p>grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident and staff interview, and policy review, it was determined the facility failed to ensure residents were provided assistance with bathing consistent with their needs. This was true for 2 of 2 (#1 and #5) residents sampled for bathing. This failure created the potential for residents to experience embarrassments, isolation, decreased sense of self-worth, skin impairment and compromised physical and psychosocial well-being. Findings include:</p> <p>The facility's policy titled, NSG200 Activities of Daily Living (ADLs), last revised 11/28/16, did not specify the number of baths residents were to receive.</p> <p>1. Resident #1 was admitted to the facility on 1/3/18 with multiple diagnoses, including chronic interstitial cystitis (bladder pain) and chronic nephritis (inflammation of the kidneys).</p> <p>Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 7/16/18, documented her cognition was severely impaired and she required extensive assistance from one person for most activities of daily living (ADLs.) The MDS assessment documented Resident #1 was not bathed during the 7 days prior to the assessment.</p> <p>Resident #1's July 2018 ADL record documented she received a shower on 7/4/18, 7/7/18, 7/9/18, and 7/21/18. The ADL record documented Resident #1 refused bathing on 7/18/18, and all</p>	F 677	<p>Residents Affected: Resident #1 Care Plan was revised with resident preferences for bathing, bathing assistance required, frequency of bathing, and bathing schedule on or before 08/31/2018.</p> <p>Potential Residents Affected: A care plan audit was conducted on or before 09/07/2018 by the Center Nurse Executive (CNE) or designee to insure that all residents bathing preferences, assistance required, and bathing schedules; including frequency are consistent with resident choice and preferences. Any concerns or issues were addressed by the CNE or designee at the time of identification.</p> <p>An ADL documentation audit was conducted on or before 09/07/2018 by Center Nurse Executive or designee to insure direct care staff are documenting accurately and consistently including bathing, bathing assistance, and bathing schedules and frequency. Any concerns or issues were addressed by the CNE or designee at the time of identification.</p> <p>Systematic Change/Education: Beginning the week of 09/03/2018, new admissions will be reviewed in morning clinical meeting by CNE or designee to</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 677	<p>Continued From page 8</p> <p>other entries documented "not applicable." Resident #1 did not receive a bath/shower between 7/9/18 and 7/21/18, 11 days.</p> <p>Resident #1's June 2018 ADL record documented she received a shower on 6/2/18, 6/4/18, 6/6/18, 6/9/18, 6/15/18, and 6/18/18. There were no documented Resident refusals on the ADL record and all other entries documented "not applicable."</p> <p>A care plan problem, dated 1/4/18, documented Resident #1 required assistance/was dependent on staff for bathing. The care plan did not provide interventions to staff for completion of bathing.</p> <p>On 7/24/18 at 2:00 PM, Resident #1 stated she was scheduled for one shower per week. She stated the schedule for her showers have changed, first it was Thursdays, then it went to Fridays, then Mondays. Resident #1 stated when she first admitted she received 2 showers a week. Resident #1 stated she needed more showers.</p> <p>On 7/25/18 at 2:00 PM the Interim Certified Nurse Educator, Regional Registered Nurse Manager was interviewed about residents' bathing. He stated the residents were to receive at least two baths a week.</p> <p>2. Resident #5 was admitted to the facility on 11/29/17 with diagnoses of periprosthetic fracture around internal prosthetic left hip joint (broken bone that occurs around the implants of a total hip replacement). Resident #5 was discharged on 12/12/17.</p>	F 677	<p>insure care plans related to bathing, bathing assistance, bathing schedule and frequencies are consistent with resident preferences.</p> <p>Beginning the week of 09/03/2018, residents care plans will be reviewed by CNE or designee during quarterly care conferences, upon change of condition, or resident/family request for bathing, bathing assistance, and bathing schedule and frequency to insure bathing is consistent with resident preferences.</p> <p>Licensed Nurse staff will be educated by CNE or designee on or before 09/07/2018 on resident preferences and care plans related to bathing, bathing assistance, and bathing schedule and frequency.</p> <p>Direct Care Staff will be educated by CNE or designee on or before 09/07/2018 on ADL documentation, including bathing and resident bathing schedules and frequency.</p> <p>Monitors: Beginning the week of 09/10/2018, an audit of 10 resident care plans related to bathing, bathing assistance, bathing schedule and frequency are consistent with resident preferences and choice will be conducted by CNE or designee. These audits will be conducted weekly x4 weeks and then monthly x2 months.</p> <p>Beginning the week of 09/10/2018, an audit of 10 resident ADL charting will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 677	Continued From page 9 Resident #5's care plan, dated 11/30/17, documented here required assistance with bathing related to a left hip fracture, dementia, and pain. The interventions did not specify how often Resident #5 was to receive a bath.  Resident #5's ADL record documented from 11/29/17 to 12/12/17, he did not receive a bath from 12/1/17 through 12/6/17. The ADL record documented Resident #5 refused a bath on 12/1/17, and was next offered a bath on 12/7/17, a total of 6 days without a bath.  On 7/25/18 at 2:00 PM the Interim Certified Nurse Educator, Regional Registered Nurse Manager was interviewed about residents' bathing. He stated the residents were to receive at least two baths a week and agreed the resident did not get the two baths.	F 677	conducted by CNE or designee to insure bathing assistance, schedule, and frequency are consistent with resident care plan. These audits will be conducted weekly x4 weeks and then monthly x2 months.  The results of these audits will be complied and reported to the QAPI committee for review monthly for 3 months or until substantial compliance is maintained. The Center Nurse Executive is responsible for monitoring and follow-up.		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		9/12/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 686	<p>Continued From page 10</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents did not develop avoidable pressure ulcers. This was true for 1 of 3 residents (#13) reviewed for pressure ulcers. Resident #13 was harmed when he developed 2 pressure ulcers on his buttocks. Findings include:</p> <p>Resident #13 was readmitted 6/8/18. He had been discharged on 6/5/18 to the hospital with diagnosis of pneumonia and sepsis. He had additional diagnoses of chronic kidney disease stage 3 and left knee, ankle, and foot pain.</p> <p>Resident #13's 6/8/18 Skin Check assessment documented he did not have skin impairments.</p> <p>An initial nursing assessment completed on 6/8/18 at 4:14 PM documented Resident #13's skin was constantly moist, of normal color, and warm to the touch with a skin impairment present. The assessment did not include the size, location, or description of the skin impairment.</p> <p>A 6/8/18 Physician Order Summary Report documented the following:</p> <p>* "Evaluate wound area daily..report to MD (medical doctor) as indicated." * "(Name of wound care agency) may eval(uate) and treat" the wound.</p> <p>The Order Summary Report did not include the location of the wound.</p> <p>Resident #13's Progress Note of 6/10/18 at 3:02 PM, documented his skin was intact except for a</p>	F 686	<p>Residents Affected: Resident #13 discharged from Genesis Meridian Center on 07/23/2018.</p> <p>Potential Residents Affected: A review of center residents' skin will be completed by a licensed nurse on or before 09/07/2018. Follow-up will be completed for any previously unidentified impairment including assessment, physician and family notification, and care plan updates as indicated.</p> <p>Center residents skin assessments, care plans, and physician orders for skin assessment/ treatment will be reviewed with follow-up completed by the center nurse executive or designee on or before 09/07/2018 to ensure that resident assessment schedule and measures for prevention are in place, and sufficient based on resident assessed risk.</p> <p>Systemic Change/Education Beginning the week of 09/03/2018 center residents assessed to be at high risk for skin breakdown will have a comprehensive skin check completed 2x weekly by the licensed nurse to improve early identification of skin issues.</p> <p>Beginning the week of 09/03/2018 Center residents who are new admission or those who have a significant change of condition will have their risk for skin breakdown reviewed by the center nurse executive or designee at morning clinical to determine frequency of skin check/</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 686	<p>Continued From page 11</p> <p>DTI on his left foot. The facility had a contract with an outside agency to provide wound assessments. A wound assessment completed by the contract agency's staff on 6/13/18 documented the left dorsal foot wound.</p> <p>Resident #13's MDS assessment, dated 6/15/18, documented he had two unstageable deep tissue injuries (DTI).</p> <p>Resident #13's 6/15/18 Skin Check assessment documented he had new skin injury wounds. The new wounds were:</p> <p>* "dark red/purple scratch/blood blister to right buttock, .3 cm (centimeters) x 0.7 cm [and the depth was] UTD (unable to determined)"</p> <p>* "Red blanchable area bilateral inner buttocks 5 cm x 6.5 cm x 0 cm."</p> <p>A Progress Note, dated 6/15/18 at 5:00 PM included documentation of a change in condition of "Skin wound or ulcer 06/15/2018 in the afternoon."</p> <p>A Progress Note, dated 6/16/18 at 6:00 PM, documented Resident #13's right buttock area had areas of skin peeling with a pink, moist underlying wound base. The note stated there were no signs of infection or drainage. The note also documented the moisture associated skin damage to Resident #13's bilateral inner buttocks was less red.</p> <p>A Progress Note, dated 6/22/18 at 4:55 PM documented the blanchable area to Resident #13's right buttock was healed.</p>	F 686	<p>evaluation.</p> <p>Beginning the week of 09/03/2018 a review of any newly identified skin impairment will be completed by the Center Nurse Executive or designee at morning clinical meeting to ensure that wound monitoring including frequency of evaluation are updated based on resident assessed risk.</p> <p>Licensed nurses were re-educated on pressure ulcer prevention, skin assessment, and Genesis skin system including frequency of assessment, and following physician orders by the center nurse practice educator or designee on or before 09/07/2018.</p> <p>Nursing staff including licensed nurses and certified nursing assistants will be re-educated by the center nurse executive or designee on pressure ulcer prevention measures, and following the plan of care on or before 09/07/2018. Licensed nurses will complete/ pass a skin check competency to validate competency with skin assessment on or before 09/07/2018.</p> <p>Monitors: Beginning the week of 09/10/2018 an audit of 5 residents will be completed by the center nurse executive or designee to ensure that there are no previously unidentified skin issues, and that care plan and physicians' orders for pressure ulcer prevention, treatment, and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 686	Continued From page 12  A document titled RMS Event Summary Report, dated 6/27/18 at 12:00 PM, stated Resident #13 had new in-house acquired pressure ulcers, other DTI. The report documented that during wound rounds Resident #13 was found with two DTI's, one on his left proximal buttock and one on his left distal buttock. The report stated weekly skin checks were documented and the last skin check was completed on 6/22/18.  Two Skin Integrity Reports were provided by the facility. The reports documented Resident #13 had two DTIs, one on the distal left buttock and one on the proximal left buttock. The Skin Integrity Reports documented the wounds were first identified on 6/27/18. The Skin Integrity Reports documented assessments of the left distal buttock wound on 6/27/18, 7/4/18, 7/11/18, and 7/18/18. The Skin Integrity Reports documented assessments of the left proximal buttock wound on 6/27/18, 7/6/18, 7/11/18, and 7/18/18. The assessments were not completed daily as ordered by the physician on 6/8/18.  The documentation on 6/27/18, for the distal left buttock, was: appearance: 90% intact/deep purple, 10% granulation; 2 cm length; 1.5 cm width; 0 cm depth; no drainage; healthy wound edges; healthy surrounding tissues; and no odor.  The documentation on 6/27/18, for the proximal left buttock wound was: appearance: 90% intact/deep purple 10% granulation; 5 cm length; 2 cm width; 0 cm depth; no drainage; healthy wound edges; healthy surrounding tissues; and no odor.	F 686	monitoring are followed.  These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be compiled by the center nurse executive and reported to the performance improvement committee for review monthly X 3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow-up.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE MERIDIAN, ID 83642</b>		
(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 686	<p>Continued From page 13</p> <p>The distal left buttock wound was resolved by 7/18/18, and did not open into a sore. The wound on Resident #13's proximal left buttock, on 7/11/18, was described as: appearance 90% intact/deep purple and 10% granulation; 0.4 cm length; 0.5 cm width; and 0.1 cm depth; no drainage; healthy surrounding tissue; healthy wound edges; and no odor. The 7/18/18 documentation was: appearance 100% scab; 0.4 cm length; 0.5 cm width; UTD depth; no drainage; healthy surrounding tissue; healthy wound edges; and no odor.</p> <p>Resident #13 was transferred to the hospital 7/23/18 and did not return to the facility prior to the survey team's exit on 7/26/18.</p> <p>Resident #13's current care plan included multiple instructions and interventions related to wounds, including the following:</p> <ul style="list-style-type: none"> <li>* Single turn sheet for repositioning starting 3/18/16</li> <li>* Air mattress starting 4/27/16</li> <li>* Highback tilt in space wheelchair for positioning initiated 11/17/17</li> <li>* Evaluate wound daily, added 6/17/18</li> <li>* Weekly skin assessments, added 6/17/18</li> <li>* Assist and encourage turning and repositioning frequently, added on 6/28/18</li> <li>* Weekly wound assessments to include measurement and description of the wound, added 6/28/18</li> <li>* Wound (location not specified) to be evaluated daily, initiated 2/17/18</li> <li>* Bi-weekly skin checks by a licensed nurse, starting 7/12/18</li> <li>* Pressure reduction wheelchair cushion</li> </ul>	F 686			

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

PRINTED: 09/04/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN CENTER GENESIS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1351 WEST PINE AVENUE</b> <b>MERIDIAN, ID 83642</b>		
(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 686	Continued From page 14 * New wheelchair cushion ordered 7/19/18  Resident #13's care plan included conflicting information, stating his skin and wound(s) were to be assessed/evaluated daily, bi-weekly, and weekly.  The Corporate Quality Service Nurse was interviewed on 7/25/18 at 12:30 PM about the DTIs. The wound sheets were provided and she stated Resident #13 had multiple co-morbidities.	F 686			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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](mailto:fsb@dhw.idaho.gov)

January 10, 2019

Trent Clegg, Administrator  
Meridian Center Genesis Healthcare  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **July 23, 2018** through **July 26, 2018**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. Observations were conducted throughout the facility. Interviews were conducted with the resident and staff members. The resident's medical record was reviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007742**

**ALLEGATION#1:**

The Resident was receiving a laxative twice a day which led to diarrhea.

**FINDINGS #1:**

Review of the resident's medical record documented diarrhea concerns around the 03/09/17 and 05/08/17 admission time frames. Review of the nurse's documentation showed there were multiple reasons for the resident's diarrhea. The resident was admitted with an intravenous antibiotic (###) along with the pressure from the Foley catheter, which may have made the

resident feel he had to have a bowel movement. The resident on multiple occasions requested bowel medications and did have loose stools. There were multiple documented nurses notes where the staff did not feel the resident should get the medications, but honored his right for treatment and gave him what he requested. The resident had a supra-pubic catheter inserted 02/05/18 and there had not been any further requests for laxatives.

The allegation of the facility over medicating with laxative use could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The female Physical Therapist was "onery" and wrote a "nasty report" which led to the therapy being stopped.

**FINDINGS #2:**

The Resident's medical record documented Physical Therapy started therapy 08/31/17 and discharged him from Physical Therapy on 10/12/17 after reaching the therapy goals. The Progress notes and therapy documentation were reviewed and no negative comments were found. The resident was interviewed on 07/23/18 at 3:50 PM. The resident was in bed during the interview and indicated the nursing staff try to get him up, but he refuses. The resident had not had any physical therapy for several months and did not think he needed therapy. The resident stated he refuses cares and getting out of bed.

The allegation of the facility failing to provide physical therapy could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

The Resident's responsible party for the Resident's financial and healthcare needs requested a statement listing medications and charges, and had no response from the facility.

Trent Clegg, Administrator  
January 10, 2019  
Page 3 of 3

FINDINGS #3:

The investigation revealed: The complaint was filed with the State of Idaho on 02/05/18. The business office received the request dated 02/20/18. The business office responded on 02/23/18 with a full report of the resident's expenditures for the previous and current year.

The allegation of the facility failing to provide an itemized statement could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

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.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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](mailto:fsb@dhw.idaho.gov)

January 15, 2019

Trent Clegg, Administrator  
Meridian Center Genesis Healthcare  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **July 26, 2018**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007708**

**ALLEGATION #1:**

It was over an hour between when pain medication was requested and the resident received pain medication.

**FINDINGS #1:**

Two surveyors were in the facility from 07/23/18 through 07/26/18 investigating multiple complaints two residents were reviewed for pain control. The resident's medical records were reviewed.

Review of the Resident's record showed the resident was admitted to the facility 11/29/17 and discharged 12/12/17. The MDS assessment note, dated 12/06/17, by the RN, documented: "He (###) has routine Tramadol and has utilized his prn Roxicodone and tramadol for pain management. When interviewed he advised his pain was occasional, has interfered with sleep, and has limited his activities."

Review of the Medication Administration Record confirmed that the resident did not wait for pain medication after he was admitted to the facility

On 12/08/17 the resident's pain medication, Tramadol, were stopped as he was having visual and auditory

hallucinations. He was started on acetaminophen for pain control.

The allegation of the facility failing to provide pain medications could not be substantiated. There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The Reporting Party said the facility's social workers pressured her into allowing the resident to discharge.

FINDINGS #2 :

Review of the Resident's Medical Records did not include documentation to show there was any problem with discharge. The Assisted Living Facility did an evaluation and a discharge was scheduled. The resident was discharged 12/12/17 with staff from the Assisted Living Facility and family.

The allegation of the facility failing to have resident ready for discharge, could not be substantiated. There was insufficient evidence to establish the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Resident had an unstageable sore on his heel when he returned to the Assisted Living Facility (ALF). The reporting party felt the sore was acquired at the Skilled Nursing Facility.

FINDINGS #3:

There were 3 residents reviewed with pressure sores.

Medical record review of the identified Resident did not show any indication there was a pressure sore. The 12/06/17 admission MDS documented the identified Resident was at risk for pressure sores, but the Resident did not have one.

During the investigation another resident reviewed did have a facility acquired pressure sore. Even though

Trent Clegg, Administrator  
January 15, 2019  
Page 3

the allegation could not be substantiated for the resident named in the complaint, the allegation was substantiated for other residents in the sample. The facility failed to respond appropriately to the subject of the allegation and deficiencies were written.

The allegation of the facility failing to prevent pressures sores was substantiated. The facility was cited with deficient practice F686 Pressure Sores for another resident reviewed at the facility. Please refer to F686 of the 2567 for the specific findings.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Resident did not have a bath "for over 2 weeks."

FINDINGS #4:

The allegation of the facility failing to bathe the resident was substantiated. The facility failed to respond appropriately to the subject of the allegation and deficiencies were written. The facility was cited with deficient practice F677 ADL care provided for Dependent Residents. Please refer to F677 of the 2567 for the specific findings.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj

Trent Clegg, Administrator  
January 15, 2019  
Page 4



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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](mailto:fsb@dhw.idaho.gov)

April 8, 2019

Trent Clegg, Administrator  
Meridian Center Genesis Healthcare  
1351 West Pine Avenue  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **July 23, 2018** through **July 26, 2018**, an unannounced on-site complaint survey was conducted at Meridian Center Genesis Healthcare. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007748**

**ALLEGATION #1:**

Residents were not provided the care and services necessary to prevent the development of pressures.

**FINDINGS #1:**

A sample of thirteen residents were reviewed. Observations were conducted throughout the facility. Multiple interviews were conducted with physicians, staff members, and two residents. Three residents' records were reviewed for wounds.

One resident's medical record documented the resident was admitted to the hospital February 5, 2018, related to an abscess. The resident did not have a pressure ulcer.

Trent Clegg, Administrator  
April 8, 2019  
Page 2 of 2

The medical record documented on January 4, 2018, a closed abscess was found on the resident's buttock. The resident's physician was contacted, and a culture to determine the type of infection causing the abscess was ordered and antibiotics were started. On January 9, 2018, the culture test showed E-Coli bacteria (type of bacteria that normally live in the intestines of people and animals). The antibiotics were changed to ones sensitive to the bacteria. On January 11, 2018, a skin assessment was completed, and the wound progressed to an open abscess. On January 16, 2018, the resident's physician examined the resident and ordered a CT scan (special X-ray tests that produce cross-sectional images of the body) of the area and a surgical consultation. The resident was still receiving antibiotics. The CT scan was completed January 19, 2018, and the physician ordered the resident referred to "General Surgery for Perirectal Abscess."

On January 27, 2018, the physician ordered the wound to have Maxsorb Ag packing (antimicrobial) daily. The resident was admitted to the hospital February 5, 2018 for surgical consultation.

While it could not be verified the resident referenced above developed pressure ulcers in the facility, another resident's record reviewed documented he developed two pressure ulcers on his buttocks while residing in the facility. Therefore, the allegation that residents were not provided care and services necessary to prevent pressure ulcers was substantiated and a deficiency was cited. Please refer to Form-CMS 2567, F686, for further details.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

Trent Clegg, Administrator  
April 8, 2019  
Page 3 of 2

LT/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – 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](mailto:fsb@dhw.idaho.gov)

July 23, 2019

Trent Clegg, Administrator  
Creekside Transitional Care and Rehabilitation  
1351 West Pine Avenue,  
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **July 26, 2018**, an unannounced on-site complaint survey was conducted at Creekside Transitional Care and Rehabilitation. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007786**

ALLEGATION #1:

Residents did not receive appropriate personal cares to prevent infection and pressure ulcers.

FINDINGS #1:

An onsite complaint survey was conducted from 7/23/18 to 7/26/18. During the investigation, 13 resident records were reviewed, observations were conducted, interviews were conducted with physicians, staff members, and two residents. Resident Council minutes and grievances were also reviewed.

Throughout the survey, resident appearance, hygiene, and personal care observations were conducted. Observations were conducted of staff providing incontinence care to two residents and urinary catheter care of one resident. No concerns were identified related to the care provided

during the observations.

Of the 13 resident records reviewed, four were reviewed for urinary tract infections (UTI). One resident was diagnosed with a UTI twice in three months. There were no concerns related to UTI care. However, three residents were reviewed for wounds and one record documented a resident did develop a pressure sore at the facility.

Additionally, resident care plans did not consistently include comprehensive information related to bathing. One resident's care plan did not include the frequency of baths/showers, the level of assistance required for them, or preferences the resident may have had. When asked about the resident's care plan, on 7/25/18 at 3:00 PM, the Interim Director of Nursing reviewed the care plan and stated he could not find assessed needs, goals, or preferences.

The records of two residents did not include documentation they were provided with bathing assistance consistent with their needs. This created the potential for residents to experience embarrassments, isolation, decreased sense of self-worth, skin impairment, and compromised physical and psychosocial well-being.

When asked, on 7/25/18 at 2:00 PM the Interim Certified Nurse Educator, Regional Registered Nurse Manager stated the residents were to receive at least two baths a week.

It was determined a resident developed a pressure ulcer and the facility failed to ensure residents received adequate assistance with bathing and care planning.

Based on the investigative findings the allegation was substantiated and deficient practice was cited at F686 related to pressure ulcers, at F656 related to care planning, and at F677 related to assistance with bathing.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

Residents lost weight because the food was not palatable.

#### FINDINGS #2:

During the investigation 13 resident records were reviewed, including two residents whose records were reviewed for weight loss. Observations were conducted during meal times, facility policies were reviewed, residents were interviewed and staff were interviewed.

One resident's record documented weight loss during the first month after their admission. The resident received a therapeutic diet that limited salt intake and spices. The resident's record included documentation of several changes in diet orders to increase the flavor of the food. The resident's weight, during the most recent six month period, documented a weight gain.

Meal service in the dining room and on the 200 hall were observed daily during the survey and two residents were interviewed regarding food palatability. One resident stated the facility served too many soups and cakes. The resident stated the salads were good.

During a meal observation on 7/25/18 at 12:25 PM, a resident was seated at a table with one other resident for lunch. One resident had her meal in front of her and was seasoning her food with salt and pepper while the other resident had a coffee cup in front of her but no food. At 12:30 PM, the resident asked, "Why does it take so long to get my food?" The resident did not receive her food until 12:50 PM, 25 minutes after her tablemate received her food.

The facility's Meal Service in Dining Room policy, dated 6/1/96, was reviewed. The policy directed staff to serve all residents at a table at the same time.

When asked, on 7/25/18 at 1:30 PM, the Registered Dietitian stated residents seated at the same table should be served at the same time.

Based on the investigative findings the allegation could not be substantiated. However, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times and a deficient practice was cited at F550.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

Resident bathrooms were not clean and toilets did not work properly.

#### FINDINGS #3:

During the investigation, observations were conducted, Resident Council minutes were reviewed, and grievances were reviewed.

On the 200 hall, 15 bathrooms were observed daily during the survey. The bathrooms were clean and there were no toilets observed to be leaking. Resident Council Minutes, dated 2/2018 -

Trent Clegg, Administrator  
July 23, 2019  
Page 4 of 4

7/2018, did not include documentation of resident concerns regarding the cleanliness of the bathrooms or toilets.

Two grievances, dated 1/2018 and 5/2018, documented a concern with the cleanliness of one resident's bathroom. The facility responded to the grievances within 24 hours and the resident was satisfied with the resolution.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Thank you for the courtesies and assistance extended to us during our visit. 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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/slj