



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

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

October 22, 2018

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

Provider #: 135125

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Clegg:

On **October 9, 2018**, a Facility Fire Safety and Construction survey was conducted at **Meridian Center Genesis Healthcare** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 5, 2018**. Failure to submit an acceptable PoC by **November 5, 2018**, may result in the imposition of civil monetary penalties by **November 26, 2018**.

Your PoC must contain the following:

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

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 13, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 13, 2018**. A change in the seriousness of the deficiencies on **November 13, 2018**, may result in a change in the remedy.

Trent Clegg, Administrator
October 22, 2018
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **November 13, 2018**, includes the following:

Denial of payment for new admissions effective **January 9, 2019**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 9, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 9, 2018**, 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:

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

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

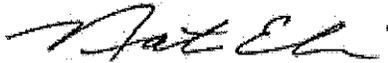
BFS Letters (06/30/11)

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

This request must be received by **November 5, 2018**. If your request for informal dispute resolution is received after **November 5, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 10/19/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2018
NAME OF PROVIDER OR SUPPLIER MERIDIAN CENTER GENESIS HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single-story Type V (III) construction completed in March 1997. The facility is fully sprinklered and has a complete fire alarm system with smoke detection and fire dampers throughout. There is a partial upper level that is only used for storage, staff training, and offices. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is currently licensed for 139 SNF/NF beds, and had a census of 86 on the date of the survey. The following deficiencies were cited during the annual life safety code survey conducted on October 9, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		

RECEIVED
NOV 02 2018
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Administrator** (X6) DATE **11/2/18**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 324	<p>Continued From page 1</p> <p>compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</p> <p>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</p> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen hood system, specifically, grease filters, in accordance with NFPA 96. Failure to maintain grease filters could increase the risk of fires due to excessive build-up of grease laden vapors. This deficient practice affected staff and visitors in the kitchen on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 9, 2018, from approximately 8:30 AM to 1:30 PM, inspection of the hood system revealed several broken baffles, allowing grease laden vapors to enter the duct system unfiltered. When asked, the Maintenance Supervisor stated the facility was unaware the grease filters were broken.</p> <p>Actual NFPA standard:</p>	K 324		

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K 324	Continued From page 2 NFPA 96 4.1 General. 4.1.1 Cooking equipment used in processes producing smoke or grease-laden vapors shall be equipped with an exhaust system that complies with all the equipment and performance requirements of this standard. 4.1.2 All such equipment and its performance shall be maintained in accordance with the requirements of this standard during all periods of operation of the cooking equipment. 4.1.3 The following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment 4.1.3.1 Maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. 6.2.3 Grease Filters. 6.2.3.2 Grease filters shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions.	K 324		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		

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K 353	<p>Continued From page 3 available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, and interview, the facility failed to inspect, test and maintain the fire suppression system in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system performance during a fire event. This deficient practice affected 86 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records on October 9, 2018, from approximately 8:30 AM to 1:30 PM, fire suppression inspection reports revealed dry sprinkler pendants had been identified on the annual sprinkler inspection report dated August 20, 2018 as exceeding 10 years of service. No documentation could be produced for the testing or replacement of the dry sprinkler pendants. When asked, the Maintenance Supervisor stated the facility was not aware of the requirement to test or replace dry sprinkler heads every 10 years.</p> <p>Actual NFPA standard:</p>	K 353		

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K 353	Continued From page 4 NFPA 25 5.3 Testing. 5.3.1* Sprinklers. 5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals.	K 353		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918		

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K 918	<p>Continued From page 5</p> <p>circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the generator for the EES (Essential Electrical System) was maintained in accordance with NFPA 110. Failure to inspect and test EES generators could result in a lack of system reliability during a power loss. This deficient practice affected 86 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the facility generator inspection and testing records on October 9, 2018, from approximately 2:00 PM to 5:00 PM, the facility failed to provide documentation for an annual load test of the generator. The last known annual load test was completed on May 23, 2017. Additionally, no documentation for a three-year, four-hour load test or testing of the diesel fuel quality could be produced. When asked, the Maintenance Supervisor stated the facility was unaware of the missing inspections and load test requirements.</p> <p>Actual NFPA standard:</p> <p>NFPA 110 8.3 Maintenance and Operational Testing. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM</p>	K 918		

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K 918	Continued From page 6 standards. 8.4 Operational Inspection and Testing. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating 8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATSSs, or initiated by opening all switches or breakers supplying normal power to all ATSSs that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3.	K 918		

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K 918	<p>Continued From page 7</p> <p>8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement.</p> <p>8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test.</p> <p>8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS.</p>	K 918		



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October 22, 2018

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RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Clegg:

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Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
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The remedy, which will be recommended if substantial compliance has not been achieved by **November 13, 2018**, includes the following:

Denial of payment for new admissions effective **January 9, 2019**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 9, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **October 9, 2018**, 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)

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

Trent Clegg, Administrator
October 22, 2018
Page 4 of 4

This request must be received by **November 5, 2018**. If your request for informal dispute resolution is received after **November 5, 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, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

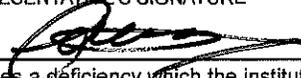
PRINTED: 10/19/2018
FORM APPROVED
OMB NO. 0938-0391

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 10/09/2018
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
E 000	Initial Comments The facility is a single-story Type V (III) construction completed in March 1997. The facility is fully sprinklered and has a complete fire alarm system with smoke detection and fire dampers throughout. There is a partial upper level that is only used for storage, staff training, and offices. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. The facility is currently licensed for 139 SNF/NF beds, and had a census of 86 on the date of the survey. The following deficiency was cited during the emergency preparedness survey conducted on October 9, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	E 000	RECEIVED NOV 02 2018 FACILITY STANDARDS	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the	E 039		

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

TITLE

(X6) DATE



Administrator

11/2/18

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: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2018	
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
E 039	<p>Continued From page 1 following:]</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based.</p> <p>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an</p>	E 039		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 039	<p>Continued From page 2 emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to test the emergency preparedness plan annually. Failure to test the emergency preparedness plan annually, has the potential to hinder staff response during a disaster. This deficient practice affected 86 residents, staff and visitors on the date of the survey.</p> <p>Findings Include:</p> <p>Review of the facility Emergency Preparedness (EP) plan on October 9, 2018, from approximately 2:00 PM to 5:00 PM, revealed a written EP testing program, and two facility-based exercises. However, there had not been a full-scale, community-based exercise in the last 12 months. When asked, the Administrator stated the facility had not yet planned or participated in a community-based full-scale exercise this year. No documentation could be produced to show the facility had attempted to contact community emergency responders.</p> <p>Reference:</p> <p>42 CFR 483.73 (d) (2)</p>	E 039		