



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
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January 10, 2020

Joe Rudd, Administrator  
Meridian Meadows Transitional Care  
2656 E. Magic View Drive  
Meridian, ID 83642

RE: January 9, 2020 Initial Certification Survey Report for Meridian Meadows  
Transitional Care

Dear Mr. Rudd:

This is to advise you of the findings of the **Medicare** initial survey of Meridian Meadows Transitional Care, which was done on **January 9, 2020** by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility is in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, which states that there were no deficiencies cited and that **Meridian Meadows Transitional Care** is in substantial compliance with **Medicare** rules and regulations. This form is for your records only and need not be returned to this office.

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

Enclosures

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

PRINTED: 02/18/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135147</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/09/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERIDIAN MEADOWS TRANSITIONAL CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2656 E MAGIC VIEW DRIVE 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	<p><b>INITIAL COMMENTS</b></p> <p>On January 9, 2020, an initial federal certification survey of your facility was completed. Meridian Meadows Transitional Care was found to be in compliance with the requirements of 42 CFR Part 483 Subpart B, Requirements for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were: Debby Ransom, RN, RHIT Belinda Day, RN Laura Thompson, RN</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.