STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135147	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Meadows Transitional Care	2656 E Magic View Drive Meridian, ID 83642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the Long-Term Care Reporting Portal, it was determined that the facility failed to ensure residents were free from neglect. This was true for 3 of 6 residents (#3, #10, and #20) whose records were reviewed for abuse and neglect. This failure resulted in harm when Resident #3 was injured during a transfer and created the potential for embarrassment and psychosocial harm when Resident #10 and Resident #20 were not provided timely incontinence care. Findings include:The facility's Abuse and Neglect policy, dated 12/2/24, documented that the facility will identify events, occurrences, patterns, and trends that may constitute neglect-defined as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.The facility's Safe Resident Handling/Transfer policy, dated 12/20/24, documented that two staff members must be utilized when transferring residents with a full mechanical lift.1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (a condition that occurs when the blood flow to part of the brain is obstructed), hemiplegia (paralysis or weakness on one side of the body), and major depressive disorder. Resident #3's care plan, dated 5/15/23, directed staff to perform two-person transfers using the mechanical lift. An MDS quarterly assessment, dated 3/30/25, documented that Resident #3 was unable to go from a sitting to standing position and was dependent on staff for transfers (meaning all efforts were done by staff). Review of the Long-Term Care Reporting Portal revealed an incident dated 3/31/25, documenting that Resident #3 was being transferred in a full mechanical lift when the sling detached, and she fell, landing on her left arm. A progress note dated 3/31/25 at 7:20 PM, documented CMA #1 entered Resident #3's room to administer medications and noted she was ready to be transferred with the sling underneath her. CMA #1 left the room to obtain the mechanical lift and request help, but no one was available. The note documented CMA #1 hooked the sling to the mechanical lift and initiated the transfer on his own. He documented during the transfer the sling became unhooked, and the mechanical lift began to tilt to the right side. CMA #1 documented Resident #3 fell landing on her left arm. Resident #3 was assessed for injuries, and a small bruise was located on her right hand. During the initial assessment Resident #3 verbalized an 8 out of 10 pain level. The note concluded all appropriate parties were notified of the incident and Resident #3 was being monitored by the nursing staff. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135147	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Meadows Transitional Care	2656 E Magic View Drive Meridian, ID 83642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility's Incidents and Accidents (I&A) record dated 3/31/25 documented that Resident #3 was being transferred in a full mechanical lift when the sling detached, and she fell, landing on her left arm. The I&A documented that X-ray services were provided on 4/1/25, revealing that Resident #3 sustained a comminuted fracture (a bone broken in at least two places). Pain management and orthopedic services were provided. The report also included notification of all appropriate parties, as well as staff education and disciplinary actions taken. The facility's I&A report documented that the investigation determined the allegation of neglect was confirmed due to CMA #1 deviating from Resident #3's plan of care by attempting to transfer her alone. On 9/3/25 at 2:47 PM, the Administrator confirmed that the incident involving Resident #3 was substantiated as neglect. 2. Resident #10 was admitted on [DATE] with multiple diagnoses including non-dominant sided hemiplegia and dysphagia (difficulty swallowing) after a stroke, and insomnia. The facility's Grievance Log documented Resident #10 filed a grievance against CNA #2 on 4/8/25. The grievance documented “Resident [#10] states that whenever [CNA #2] works; the resident does not get [incontinence care]. The grievance report documented this allegation was verified when staff watched the camera footage from the night in question, 4/6-4/7/25, and [CNA #2] had “only attended to Resident #10 once throughout their shift from 10 PM to 6 AM.” On 9/4/25 at 10:04 AM, the Administrator stated, Resident #10's allegation of neglect was likely verified based on the evidence documented on the grievance report and Resident #10 was assessed and there was no evidence of physical or psychosocial harm following the incident. 3. Resident #20 was admitted to the facility on [DATE] with multiple diagnoses including severe vascular dementia (cognitive decline caused by damaged blood vessels in the brain, chronic kidney disease, and diabetes. Review of the Long-Term Care Reporting Portal revealed an incident dated 4/10/25 which documented Resident #20 was identified to have been left soiled by CNA #2 on 4/7 when the oncoming staff took over their assignments. The facility's Investigation Report documented in a chronological summary, review of facility camera footage on the night of 4/6-4/7/25, CNA #2 had extended absences from the floor and minimal resident care provided. On 9/4/25 at 10:04 AM, the Administrator stated, the investigation confirmed CNA #2 failed to perform care for Resident #20, and Resident #20 was assessed and there was no evidence of physical or psychosocial harm following the incident. Corrective actions taken by the facility on 4/8/25 to prevent incident from reoccurrence included: CMA received formal written counseling and education on safe transfers, and two persons assist required for total lifts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135147	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Meadows Transitional Care	2656 E Magic View Drive Meridian, ID 83642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Nursing staff education on transfer protocols and resident neglect, including supervisor follow-up and observations to ensure compliance with transfers and resident care. Facility reinforced the two-person Hoyer lift policy and emphasized expectations for staff to use facility radios for additional assistance. Facility has taken appropriate measures to ensure further compliance with the incident as of 4/8/25 and is cited at past non-compliance at F600.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135147	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Meadows Transitional Care	2656 E Magic View Drive Meridian, ID 83642

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure allegations of neglect were reported to the State Agency within the regulated time period. This was true for 2 of 6 residents, (#3, and #10) who were reviewed for abuse and neglect. This failure had the potential to affect all residents in the facility and placed them at risk for harm related to neglect. 1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including cerebral infarction (a condition that occurs when the blood flow to part of the brain is obstructed), hemiplegia (paralysis or weakness on one side of the body), and major depressive disorder. A review of the facility's Incidents and Accidents (I&A) record dated 3/31/25 documented that Resident #3 was being transferred in a full mechanical lift when the sling detached, and she fell, landing on her left arm. The I&A documented that X-ray services were provided on 4/1/25, revealing that Resident #3 sustained a comminuted fracture (a bone broken in at least two places). Pain management and orthopedic services were provided. The report also included notification of all appropriate parties, as well as staff education and disciplinary actions taken. The facility's I&A report documented that the investigation determined the allegation of neglect was confirmed due to CMA #1 deviating from Resident #3's plan of care by attempting to transfer her alone. On review of the Long-Term Care Reporting Portal an incident reported on 4/2/25, documented that on 3/31/25, Resident #3 was being transferred in a full mechanical lift when the sling detached, and she fell landing on her left arm. On 9/3/25 at 2:47 PM, the Administrator stated if the incident triggered an investigation for neglect my reporting date of 4/2/25 would be considered late reporting however, we did not identify the incident as neglect until the injury was confirmed on 4/1/25. 2. Resident #10 was admitted on [DATE] with multiple diagnoses including non-dominant sided hemiplegia and dysphagia (difficulty swallowing) after a stroke, and insomnia. Review of the facility's Grievance Logs, Resident #10 made an allegation of neglect on 4/8/25. Review of the State Agency's Long Term Care Reporting Portal, Resident #10's grievance was included in another investigation initiated on 4/10/25, however, Resident #10's name was not associated with the other investigation. On 9/3/25 at 3:24 PM, the Administrator stated Resident #10's allegation of neglect should have been reported to the State Agency when he received it.