IDAHO DEPARTMENT OF

HEALTH & WELFARE

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

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

January 8, 2015

Joseph Rudd, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

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

Dear Mr. Rudd:

On **January 5, 2015**, a Facility Fire Safety and Construction survey was conducted at **Apex Center** 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 and a similar State Form 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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 21, 2015.** Failure to submit an acceptable PoC by **January 21, 2015**, may result in the imposition of civil monetary penalties by **February 10, 2015.**

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 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 9, 2015**, (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 **February 9, 2015.** A change in the seriousness of the deficiencies on **February 9, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 9, 2015**, includes the following:

Denial of payment for new admissions effective **April 5, 2015.**
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 **July 5, 2015**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **January 5, 2015**, 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:

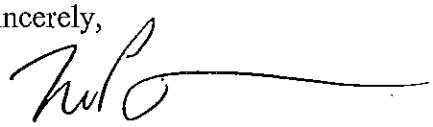
BFS Letters (06/30/11)

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

This request must be received by **January 21, 2015**. If your request for informal dispute resolution is received after **January 21, 2015**, 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.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 consists of two Type V (111) buildings that are separated by a breezeway. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinkled and equipped with a fire alarm/smoke detection system which includes smoke detection in sleeping rooms as well as corridors and open spaces. The facility is licensed for 148 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on January 5, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	RECEIVED JAN 21 2015 FACILITY STANDARDS "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure a one hour fire resistance rating of the building. Failure to maintain the fire resistive properties of the structure would increase the risk and exposure of fire events affecting life safety. This deficient practice affected 22 residents, staff and visitors on the	K 012	**K012** **RESIDENT SPECIFIC** The open walls and penetrations noted in the construction areas of the East Kitchen dishwashing area and mop room have been closed and sealed on or before February 9, 2015 by the facility Maintenance Director or Designee. **OTHER RESIDENTS** All residents can be at risk from compromised fire and smoke barriers. Repair of these barriers will protect all residents. Areas under construction in the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: TB Rdd
TITLE: Administrator
(X6) DATE: 12115

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 012	Continued From page 1 date of the survey. The facility is licensed for 148 beds and had a census of 82 on the day of the survey. Findings include: 1) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM, observation of the dishwashing area in the East Wing Kitchen, found an approximately sixteen foot by four foot section of the wall abutting the dining room had been opened exposing the dining side. Further investigation found five unsealed penetrations varying from 3/4 inch diameter up to 2 inch diameter and from 1 inch by 1 inch square, up to four inch by four inch square passing through the wall into a cabinet inside the dining hall. Inspection of the interior of the cabinet showed light coming in from the dishwashing area. During this timeframe, ten residents were observed to be using the dining hall for meals with five staff members in attendance. Return to this area from 1:00 PM to 1:45 PM found twelve residents using the dining hall for meals with six staff members in attendance. Both observations found no vendors working on the repairs of the area for the duration of the survey. 2) During the facility tour conducted on January 5, 2015 from 1:00 PM to 1:45 PM, observation of the mop room inside the Kitchen found an approximately four foot by four foot open section of the wall exposing the framing members of the corridor wall and the intersecting dishwashing area wall. When asked about the open walls and penetrations, the Maintenance Supervisor stated these areas had been opened up due to plumbing	K 012	center have been checked by the facility Maintenance Director or designee for compromised fire or smoke barriers. Open areas will be corrected when found and the contractor will be educated on Life Safety Code Standards by the facility Maintenance Director or designee **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance reqnirements with K012. **MONITORS** Beginning the week of February 9, 2015 weekly for four weeks and then monthly for two months the Maintenance Director or designee will report to the administrator findings and any required repairs regarding the construction site audits from the preceding week. . The facility safety committee, as part of the facility's Quality Assurance and Performance Improvement process will evaluate these findings for compliance with the Life Safety Code and implement corrections as needed. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 012	Continued From page 2 repairs and leaks. He further stated he was not sure why continued remediations of the project were currently ceased by the vendor. Actual NFPA standard: 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on	K 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 012	Continued From page 3 either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided	K 012		
K 021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous area doors were held open with approved releasing devices. Failure to ensure hazardous area doors were	K 021	**K021** **RESIDENT SPECIFIC** The drop-down door chocks on the West wing Kitchen double acting doors have been removed by the Maintenance Director or designee on or before February 9, 2015. The chain used to secure the door leading from the West Kitchen to the service corridor has been removed by the Maintenance Director or designee on or before February 9, 2015. **OTHER RESIDENTS** Use of a device that does not automatically release to hold open any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure has the potential to affect all residents of the facility. Removal of these devices will protect all residents. The facility Maintenance Director, or Designee, on or before February 9, 2015 audited doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure to ensure that no devices that do not have an automatic release are used to hold doors open. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 021	Continued From page 4 provided with an approved hold open device would allow smoke and dangerous gases to pass freely between compartments. This deficient practice affected residents, staff and visitors occupying the West Wing dining hall on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: During the facility tour conducted on January 5, 2015 from 1:00 PM to 2:45 PM, observation of the door from the West wing Kitchen into the dining room found it was a pair of double-acting bar style doors held open with a drop-down door chock. Further investigation of the Kitchen found the door leading from the Kitchen into the service corridor was held open by a chain wrapped around the handle and secured to the Kitchen wall. When asked, the Maintenance Supervisor stated he was not aware the door chock was not acceptable, but that he knew chaining open the door to the corridor was not permitted. Actual NFPA standard: 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. 7.2.1.8.2	K 021	**MONITORS** Beginning the week of February 9, 2015, weekly for four weeks and then monthly for two months the Maintenance Director or designee will audit doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure to ensure that no devices that do not have an automatic release are used to hold doors open; and will report to the administrator findings of any identified unapproved hold-open devices and the correction for found devices from the preceding week. The administrator will implement corrective action as required. . The facility Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process will evaluate these findings for compliance with the Life Safety Code and implement corrections as required. **Date of Compliance** February 9, 2015	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 021	Continued From page 5 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 021		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	**K025** **RESIDENT SPECIFIC** Missing tiles from the suspended ceiling outside of room 721 were replaced by the Maintenance Director or Designee on or before February 9, 2015. **OTHER RESIDENTS** Residents in all areas of the facility have the potential to be affected by missing ceiling tiles which compromise the smoke penetration barrier of the facility The Maintenance Director, or Designee, on or before February 9, 2015 has checked for missing or broken ceiling tiles throughout the facility and has replaced any which were found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 025	Continued From page 6 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maitained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and inhibit suppression and initiating system performance during a fire event. This deficient practice affected staff and visitors of the 700 wing on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: During the facility tour conducted on January 5, 2015 from 2:45 PM to 4:00 PM, observation of the suspended ceiling outside room 721 found three (3) missing ceiling tiles. When asked why these tiles were removed, the Maintenance Supervisor stated they had been removed to repair a sprinkler leak. Actual NFPA standard: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with	K 025	**FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K025. **MONITORS** Beginning the week of February 9, 2015 for four weeks and them monthly for two months, the facility Maintenance Director will audit areas of the facility for missing or broken ceiling tiles. The results of these audits will be reported to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 025	Continued From page 7 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing	K 029	**K029** **RESIDENT SPECIFIC** On or before February 9, 2015 the pass-through door in the east kitchen was walled-in by the facility Maintenance Director or Designee, eliminating the need for the accordion doors. On or before February 9, 2015 the pass-through door in the west kitchen was enclosed with a fire/smoke barrier and the double acting doors in the west kitchen have been replaced with doors which meet the Life Safety Code standard by the facility Maintenance Director or Designee to prevent smoke passage through the gap. On or before February 9, 2015 self-closing device on the door to the Central Supply in the East wing was repaired by the facility Maintenance Director or designee to cause it to close correctly. **OTHER RESIDENTS** Doorways or gaps in openings which allow smoke or hazardous gases to pass from Hazardous Areas have the potential to pose a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 029	Continued From page 8 doors that would resist the passage of smoke. Failure to provide self-closing doors to hazardous areas would allow smoke and dangerous gases to pass freely between compartments affecting egress. This deficient practice affected all residents, staff and visitors using the dining rooms in both the East and West wings on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: 1) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM, observation of the Kitchen in the East wing found that the pass-through door from the Kitchen into the dining hall was an accordion-type, folding wood door and was not equipped with a self-closing device. Further observation and operational testing found the door leading from the Kitchen into the service corridor rubbed on the floor when activated and would not completely self-close, leaving an approximately eighteen (18) inch gap between the leading edge of the door and the door frame, the full height of the door. Interview of the Maintenance Supervisor found he was not aware of the requirement for the pass-through door being a self-closing door and the condition of the door to the corridor not fully closing. 2) During the facility tour conducted on January 5, 2015 from 2:15 PM to 4:00 PM, observation of the Kitchen in the West wing found that the pass-through door from the Kitchen into the dining hall was an accordion-type, folding wood door and was not equipped with a self-closing device. Further observation of the doors from the	K 029	risk to all residents. On or before February 9, 2015 the facility Maintenance Director or designee completed a review of Hazardous Areas to ensure that each was contained with a self-closing door that complies with the Life Safety Code. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K029. **MONITORS** Beginning the week of February 9, 2015 for four weeks and them monthly for two months, the facility Maintenance Director will audit Hazardous Areas of the facility for proper installation and function of self-closing doors. The results of these audits will be reported to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 029	Continued From page 9 Kitchen into the dining hall found they were a pair of double-acting, bar style doors and when activated left a gap between the doors of approximately 3/4 inch. Further observation of these doors found they were equipped with drop-down type door chocks. (Refer to K-021) Interview of the Maintenance Supervisor found he was not aware of the requirement of the pass-through door to self-close and had not noticed the substantial gap between the main doors entering the Kitchen prior to the survey. 3) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM, observation and operational testing of the door to the Central Supply in the East wing found it was not equipped with a self-closing device. The room measured approximately ten feet by ten feet (ie 100 sq. ft.) and contained a combustible load of paper products, adult diapers, chemicals and housekeeping supplies. Interview of the Maintenance Supervisor found he was not aware this door was required to self-close. Actual NFPA standard: 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 029	Continued From page 10 extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by:	K 062	**K062** **RESIDENT SPECIFIC** Escutcheons in the Kitchen on the West wing, in the West wing Dining Hall, and the ceiling near rooms 701/704 and 100/103 have been replaced by the Maintenance Director or Designee on or before February 9, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 062	Continued From page 11 Based on observation and interview, the facility failed to maintain sprinkler escutcheon installations. Failure to ensure that sprinkler escutcheons are installed as required in a listed assembly would allow smoke and dangerous gases to bypass system components affecting a suppression system's rated performance. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: During the facility tour conducted on January 5, 2015 from 10:30 AM to 4:00 PM, observation of the facility sprinkler pendants found that escutcheons were missing from the Kitchen in the West wing; the West wing dining hall; the ceiling at the smoke doors at rooms 701/704 and the smoke doors at rooms 100/103. Interview of the Maintenance Supervisor found he was not aware of the missing sprinkler escutcheons. Actual NFPA standard: NFPA 101 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 13	K 062	**OTHER RESIDENTS** Missing escutcheons have the potential to affect all residents. On or before February 9, 2015 an audit was completed by the Facility Maintenance Director to identify missing escutcheons throughout the facility. Any identified as missing were replaced on or before February 9, 2015 by the Maintenance Director or designee. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K062. **MONITORS** Beginning the week of February 9, 2015 the facility Maintenance Director will audit escutcheons in the facility for proper placement. Weekly for four weeks and then monthly for three months the results of these audits will be reported to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 062	Continued From page 12 3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly.	K 062		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers were installed at the correct height and readily accessible could inhibit their use during a fire event. This deficient practice affected 23 residents, staff and visitors in 3 of 16 smoke compartments on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: 1) During the facility tour conducted on January 5, 2015 from 10:30 AM to 4:00 PM, observation of the fire extinguishers located in the service/dining corridor of the West wing; the Laundry of the West wing; the connecting breezeway of the East/West wing; and the 300 hall of the East wing found that the installation of the class 2A fire extinguishers, under forty pounds, ranged between 61 inches to 75 inches to the top of the fire extinguisher. Interview of the Maintenance Supervisor found he had been made aware of the	K 064	K064 **RESIDENT SPECIFIC** On or before February 9, 2015 All Fire Extinguishers that were identified as being placed at a top height of greater than 60 inches have been moved to a height ranging no greater than 60 inches at the top and no less than 4 inches from the floor by the facility Maintenance Director or Designee. On or before February 9, 2015 the fire extinguishers which were in locked compartments and located in the smoking areas have been removed by the facility Maintenance Director or Designee. **OTHER RESIDENTS** Inadequate access to fire extinguishers has the ability to affect all residents. All fire extinguishers in the facility have been evaluated by the facility Maintenance Director or Designee on or before February 9, 2015 for accessibility and placement at the appropriate height. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K064. **MONITORS** Beginning the week of February 9, 2015 for four weeks and then monthly for two months the Maintenance Director or Designee will evaluate Fire Extinguishers in the facility for accessibility, including placement at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 064	Continued From page 13 standard requiring fire extinguishers of this type to be installed no higher than sixty inches to the top of the extinguisher. 2) During the facility tour conducted on January 5, 2015 from 10:30 AM to 4:00 PM, observation of the fire extinguishers located in both smoking areas found they were installed in locked cabinets. Actual NFPA standard: 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	proper height. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure cooking	K 069	**K069** **RESIDENT SPECIFIC** The identified equipment, not maintained/inspected equipment in the East Kitchen has been disconnected from utility services by the facility Maintenance Director or Designee on or before February 9, 2015.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 069	Continued From page 14 facilities were maintained. Failure to ensure that cooking equipment is maintained could expose the residents to fire risks due to failure of equipment. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: 1) During record review of the facility conducted on January 5, 2015 from 8:30 AM to 10:30 AM, review of the facility hood inspection reports found no inspection report for the Kitchen hood suppression system or the exhaust hood for the Kitchen in the East wing. 2) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM and from 1:00 PM to 2:00 PM, observation of the Kitchen in the East wing found that the Kitchen housed operational cooking equipment. Further investigation of the Kitchen hood inspection sticker found the last inspection for the hood had been completed in June of 2011. Interview of the Maintenance Supervisor found the facility did not use the East wing Kitchen. When asked why, the Maintenance Supervisor stated: "We have to keep two kitchens available because of the way we lease the building." Actual NFPA standard: 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception*: Where domestic cooking equipment is used for food-warming or limited cooking,	K 069	**OTHER RESIDENTS** East Kitchen equipment that is not maintained/inspected has the potential to affect all residents in that unit. On or before February 9, 2015 The Maintenance Director or Designee has inspected the East Kitchen equipment that is not maintained/inspected has been disconnected and the East Kitchen area has been converted to a storage area with an and the East Kitchen area has been converted to a storage area with an appropriate one hour fire rating appropriate one hour fire rating, to ensure that the appropriate interventions are in place **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K069. **MONITORS** Beginning the week of February 9, 2015for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit the East Kitchen area to ensure that appropriate interventions identified above remain in place. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 069	Continued From page 15 protection or segregation of food preparation facilities shall not be required. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 11.3 Inspection of Exhaust Systems. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 11.3. Table 11.3 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Frequency Systems serving solid fuel cooking operations Monthly Systems serving high-volume cooking operations such as 24-hour cooking, charbroiling, or wok cooking Quarterly Systems serving moderate-volume cooking operations Semiannually Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers Annually	K 069		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	**K072** **RESIDENT SPECIFIC** On or before February 9, 2015 the door locks identified in the storage room between resident rooms 712 and 714; the door from	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 072	Continued From page 16 No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that door locks were installed to provide a rapid means of escape during an emergency. Failure to allow the instant use of exit doors would inhibit egress during an emergency. This deficient practice affected 82 residents staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: During the facility tour conducted on January 5, 2015 from 10:30 AM to 4:00 PM, observation and operational testing of the door locks leading from the following rooms to the exit access found they were equipped with keyed entry locks which were not single operational from the egress side, but required special knowledge to unlock the door. These doors included: The storage room and the linen room in between resident rooms 712 and 714; the door from the West wing copy room into the corridor as well as into the business office/corridor exit access;the doors from the Administrator's office; the Business Office and Business Office Manager's office; room 204; room 304 (Common Room); room 116; both sides of the private dining room in the West wing; Network room; storage closet in the dining room of the East wing.	K 072	the West wing copy room in the corridor as well as into the business office/corridor exit access; the doors from the Administrators office; room 204; room 304 (Common Room); room 116; both sides of the private dining room in the West wing; Network room; storage closet in the dining room of the East wing, as well as the deadbolts in the Administrators Office and the Business Managers office; and the slide bolt locks on the Copy room door and the Business Managers door have all been removed and replaced with single action knobs and locks as appropriate by the facility Maintenance Director or Designee. **OTHER RESIDENTS** Other locks in the facility have been assessed, on or before February 9, 2015 by the facility Maintenance Director or Designee for compliance with the Life Safety Code. Inappropriate knobs and locks have been replaced. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K072. **MONITORS** Beginning the week of February 9, 2015 the Facility Maintenance Director will audit 4 random door knobs/locks for single action functionality each week for four weeks and then monthly for two months. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 072	Continued From page 17 In addition, the Administrator's office and the Business manager's office were also equipped with keyed deadbolt locks; the Copy room door and the Business Manager's office door were also equipped with slide bolt locks in addition to the keyed entry lock. When asked, the Maintenance Supervisor stated he was not aware of the requirement of the locks to be single operational and that these types of locking arrangements were used throughout the facility. Due to the extent of the findings and subsequent interview, it was determined the condition was widespread and further documentation was deemed unnecessary. Actual NFPA standard: 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one	K 072	Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 072	Continued From page 18 additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked.	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 072	Continued From page 19 (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 072		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This Standard is not met as evidenced by: Based on record review, physical inspection and interview, the facility failed to ensure drapes and curtains were provided in accordance with NFPA 701. Failure to install curtains and drapes with flame resistive properties would increase the	K 074	**K074** **RESIDENT SPECIFIC** Curtains and Drapes found in rooms 115,404, 408, 411, Common Room 315, and the Dining Hall on the East Wing not tagged for 701 rating or as treated with a fire resistant application have been removed by the Facility Maintenance Director or Designee on or before February 9, 2015. **OTHER RESIDENTS** Other residents in areas with window treatments not tagged for 701 rating or as treated with a fire resistant application have the potential to be affected by non-compliance with this regulation. On or before February 9, 2015 the Facility Maintenance Director or Designee has audited areas of the facility to ensure that all curtains or drapes are tagged as having a 701 rating or as treated with a fire resistant application. Any found not meeting this requirement have been removed. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K074.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 074	Continued From page 20 available fuel during a fire event. This deficient practice affected 67 residents, staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: 1) During record review of the facility conducted on January 5, 2015 from 8:30 AM to 10:30 AM, review of the facility records failed to show any fire treatment records for non-tagged curtains or drapes. 2) During the facility tour conducted on January 5, 2015 from 10:30 AM to 4:00 PM, physical inspection of curtains and drapes installed in resident rooms 115, 404 408 411, Common Room 315 and the dining hall of the East wing found they were not tagged for 701 rating or treated with a fire resistant application. 3) When asked if he had treated his non-tagged curtains, the Maintenance Supervisor stated: "Yeah, I knew about that. My regional said I would get hit for curtains and just wait until it came up". Actual NFPA standard: 19.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1. (See 19.3.5.5.) Exception: Curtains at showers. 10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar	K 074	**MONITORS** Beginning the week of February 9, 2015 the Facility Maintenance Director will audit 4 areas of the facility each week for four weeks and then monthly for two months to ensure that all curtains or drapes are tagged as having a 701 rating or as treated with a fire resistant application. Any found not meeting this requirement will be removed. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 074	Continued From page 21 loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.	K 074		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were in accordance with NFPA 70. Failure to properly install and maintain electrical systems and components could expose residents to risk of electrocution or fire. This deficient practice affected 82 residents, staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 82 on the day of the survey. Findings include: 1) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM, observation of the East wing Kitchen found the dishwashing area had a section of the wall missing approximately sixteen feet wide by four feet high. Further inspection found two (2) wires and a wired switch hanging loosely from the wall under repair. 2) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM, observation of the East wing Kitchen found a cord installed through the wall of the dining room into the Kitchen and plugged into the wall outlet adjacent to the door. This cord was supplying power to the	K 147	**K147** **RESIDENT SPECIFIC** On or before February 9, 2015 the following identified deficiencies have been corrected through removal, repair or replacement by the facility Maintenance Director or Designee. 1)Two wires and a wired switch hanging loosely in the East Kitchen area which was under construction; 2) the ice machine cord routed through the wall between the East Kitchen and the East Dining area; 3) the fluorescent light fixture in the Maintenance Shop plugged into a relocatable power tap;4) the relocatable power tap in the East wing Laundry areas used to supply two soap dispensers and a fluorescent light fixture; 5) 3 daisy-chained relocatable power taps in the Therapy office; 6) the extension cord plugged into a multiple plug adapter in the Riser room; 7) open electrical boxes in the 100, 400, and 700 wings above the ceiling tiles; 8) missing electrical junction box covers in the Common Room of the East wing which was under construction. **OTHER RESIDENTS** All residents have the potential to be affected by Electrical wiring and equipment not in accordance with NFPA 70, National	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 147	Continued From page 22 ice machine located inside the dining room. When asked, the Maintenance Supervisor stated he was aware this installation was prohibited. 3) During the facility tour conducted on January 5, 2015 from 1:30 PM to 2:00 PM, observation of the Maintenance shop in the East wing found a fluorescent light fixture at the ceiling plugged into a relocatable power tap which hung over a dividing wall and plugged into an outlet. 4) During the facility tour conducted on January 5, 2015 from 1:30 PM to 2:00 PM, observation of the East wing Laundry found a relocatable power tap being used to supply two soap dispensers for the commercial washers. Further inspection found the outlet was also supplying power to the overhead fluorescent lighting fixture. 5) During the facility tour conducted on January 5, 2015 from 2:30 PM to 4:00 PM, observation of the Therapy office found three (3) daisy-chained relocatable power taps being used to supply power to office equipment. When asked, the Maintenance Supervisor stated he was aware this was prohibited. 6) During the facility tour conducted on January 5, 2015 from 1:30 PM to 3:00 PM, observation of the Riser room found an extension cord plugged into an multiple plug adapter. Interview of the Maintenance Supervisor found he was not aware of this condition. 7) During the facility tour conducted on January 5, 2015 from 3:30 PM to 4:00 PM, above the ceiling inspections conducted in the 100, 400 and 700 wings found open four inch by four inch square electrical boxes with exposed wiring. These included: four (4) at the 400 wing; five (5) at the	K 147	Electrical Code 9. 1.2. Areas of the facility have been audited by the Facility Maintenance Director on or before February 9, 2015 to evaluate compliance with NFPA 70, National Electrical Code 9. 1.2. Any non-compliant findings were corrected. **FACILITY SYSTEMS** The Facility Maintenance Director was educated on or before February 9. 2015 by the corporation Regional Plant Manager regarding compliance requirements with K147. **MONITORS** Beginning the week of February 9, 2015 the Facility Maintenance Director will audit 4 areas of the facility each week for four weeks and then monthly for two months to ensure that areas of the facility are in compliance with NFPA 70, National Electrical Code 9. 1.2. Any non-compliant findings will be corrected. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. **Date of Compliance** February 9, 2015	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 147	Continued From page 23 100 wing and one (1) at the 700 wing. Interview of the Maintenance Supervisor found he was not aware of these boxes being open and knew it was an improper electrical installation. Due to the extent of this finding, it was determined the condition was widespread and further documentation was deemed unnecessary. 8) During the facility tour conducted on January 5, 2015 from 10:30 AM to 12:00 PM, observation of the Common Room in the East wing found an electrical outlet without a protective cover and a three (3) inch electrical junction box above the north exit door without a cover and exposed wiring. Interview of the Maintenance Supervisor found that the missing covers were due to a recent repair/remodeling performed in the room and the removal of an exit sign over the door. Actual NFPA standard: NFPA 70 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.8. (5) Where concealed by walls, floors, or ceilings	K 147		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED
	135079		01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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 147	Continued From page 24 or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately	K 147		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - ENTIRE FACILITY** B. WING _____	(X3) DATE SURVEY COMPLETED
	135079		**01/05/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	**8211 USTICK ROAD BOISE, ID 83704**

(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 147	Continued From page 25 closed.....	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. BUILDING 03 - ENTIRE FACILITY B. WING _____	01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The facility consists of two Type V (111) buildings that are separated by a breezeway. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinkled and equipped with a fire alarm/smoke detection system which includes smoke detection in sleeping rooms as well as corridors and open spaces. The facility is licensed for 148 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on January 5, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Please refer to "K" tags on CMS form 2567:	C 226	C 226 Please See K-012 K-021 K-025 K-029 K-062 K-064 K-069 K-072 K-074 K-147	

RECEIVED
JAN 21 2015
FACILITY STANDARDS

Idaho form

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JB Rodd | TITLE: Administator | (X6) DATE: 12115

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135079	A. BUILDING 03 - ENTIRE FACILITY B. WING _____	01/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APEX CENTER	8211 USTICK ROAD BOISE, ID 83704

(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) COMPLETE DATE
C 226	Continued From Page 1 K-012 Building construction K-021 Hazardous area door hold open devices K-025 Smoke compartment continuity K-029 Hazardous areas K-062 Sprinkler system maintenance K-064 Fire extinguisher installations K-069 Cooking facilities K-072 Means of egress components K-074 Non-treated drapes and curtains K-147 Electrical installations	C 226		