



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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P.O. Box 83720  
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FILE COPY

August 10, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, a survey was conducted at Apex Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign the Form

Joseph B. Rudd, Administrator  
August 10, 2015  
Page 2

CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 24, 2015**. Failure to submit an acceptable PoC by **August 24, 2015**, may result in the imposition of civil monetary penalties by **September 14, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

Joseph B. Rudd, Administrator  
August 10, 2015  
Page 3

A 'per instance' civil money penalty of \$5,000.00 for the instance on July 17, 2015 described at deficiency F323 (S/S: G).

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on January 17, 2016, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/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 **August 24, 2015**. If your request for informal dispute resolution is received after **August 24, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Joseph B. Rudd, Administrator  
August 10, 2015  
Page 4

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (sw)". The signature is written in dark ink and is positioned above the printed name.

NINA SANDERSON L.S.W., Supervisor  
Long Term Care

NS/dmj  
Enclosures

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

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/17/2015
NAME OF PROVIDER OR SUPPLIER  APEX CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey of your facility. The survey team entered the facility on 7/13/15 and exited on 7/17/15.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator, Brad Perry, BSW, LSW, Amy Barkley, RN, BSN, Lorraine Hutton, RN, Rebecca Thomas, RN, Kendra Deines, RN, BSN</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process conducted on September 17, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide DNS/DON = Director of Nursing Services LN = Licensed Nurse LSW=Licensed Social Worker MAR = Medication Administration Record MCO=Manager of Clinical Operations MDS = Minimum Data Set assessment MG=Milligrams PRN = As Needed UM=Unit Manager</p>	F 000	<p>"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."</p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or</p>	F 241	<p>RECEIVED SEP 20 2015 FACILITY STANDARDS</p> <p>F241 RESIDENT SPECIFIC Resident #8's family was contacted regarding sign above resident #8's bed on</p>	

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

*[Handwritten Signature]*

TITLE

Administrator

(X6) DATE

9/28/15

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

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F 241	<p>Continued From page 1</p> <p>enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and medical record review, it was determined the facility failed to ensure that staff's interactions with residents maintained and/or enhanced their dignity. This was true for 2 of 15 residents (#s 8 and 30). The failure to interact with residents in a manner that preserved their dignity and sense of self worth resulted in the potential for psychosocial harm when:</p> <ol style="list-style-type: none"> <li>1. Staff indicated to Resident #30 that she should void or evacuate her bowels in her adult brief while dining, and</li> <li>2. Staff posted private information above Resident #8's bed identifying one of her medical diagnoses.</li> </ol> <p>Findings Included:</p> <ol style="list-style-type: none"> <li>1. On 7/16/15 at 11:55 am, Random Resident #30 was observed in her wheelchair being assisted to the West Dining Room by RN #20. Resident #30 asked RN #20 if the hooyer lift was available because she needed assistance to the bathroom. RN #20 stated the hooyer was available but, "We don't have time now to take you ... but you have a brief on." Resident #30 responded, "Oh, poop in the brief, that's ok but not preferable." RN #20 proceeded to wheel Resident #30 into the dining room and placed her at a dining table.</li> </ol> <p>On 7/16/15 at 12:05 pm, RN #20 was asked why she did not assist the resident to the bathroom, but instead indicated to the resident that she</p>	F 241	<p>7/23/15 by LSW. Family was agreeable to changing the verbiage of the sign but not removing the sign which they had placed. A new sign was placed in Resident's room on or before 9/24/15 by RN unit manager or designee, which states "Please place my call light across my mid-chest for ease of use." Resident's plan of care related to use of sign was updated on or before 9/23/15 by the RN unit manager or designee.</p> <p>Resident #30 had psychosocial assessment completed by LMSW on 7/20/15, which determined no psychosocial harm was caused by the staff member's comment. Resident #30's toileting care plan was updated by the RN unit manager on or before 7/30/15.</p> <p><b>OTHER RESIDENTS</b></p> <p>Members of the IDT Management completed an audit with residents who currently reside in the facility to verify feelings of treatment with dignity by staff on or before 9/23/15 through resident interview.</p> <p>A review of resident's rooms related to use of signs outlining care and diagnoses was completed by a nurse supervisor on or before 8/14/15. Identified concerns were corrected by members of the nurse management team on or before 9/23/15. Additionally the Resident Council was provided the opportunity to discuss potential dignity concerns during a</p>	

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F 241	<p>Continued From page 2</p> <p>should evacuate her bowel into her adult brief while eating her meal. When asked if it was acceptable practice to indicate to a resident she had a brief on and could toilet in the brief, RN #20 answered, "No."</p> <p>CNA #21 was interviewed on 7/16/15 at 12:15 pm. and stated Resident #30 often experienced the urge to void and/or evacuate, but did not always demonstrate the actual need. CNA #21 stated the resident was checked at 11:00 am (before meal) and did not need to toilet. When CNA #21 was asked if it was acceptable to indicate to a resident that he/she could void and/or evacuate in their briefs, CNA #21 stated, "No."</p> <p>2. On 7/13/15 at 11:04 AM, Resident #8 was observed in her bed asleep. On the wall above the resident's head was a handwritten sign which documented, "Staff Please clip [Resident #8's] call button in the middle as she is paralyzed on her left side [and] can't reach it if you clip it on the left..."</p> <p>On 7/15/15 at 8:02 AM, the DNS was shown the sign in the resident's room. She said family put the sign up in Februray following a care conference discussion. When informed the sign disclosed private health information about the resident, the DNS removed the sign.</p> <p>On 7/15/15 at 12:45 PM, the DNS stated she could not locate care conference documentation regarding the sign, but stated the family put the sign up and not the facility.</p>	F 241	<p>resident council meeting held on or before 9/23/15,</p> <p><b>FACILITY SYSTEMS</b> Staff will be re-educated regarding the treatment of residents with dignity and respect, and on other requirements under F241, by Social Service Personnel or designee on or before 9/23/15. Facility will continue to request resident's dignity concerns monthly in resident council to identify and address any previously unidentified concerns.</p> <p><b>MONITORS</b> Beginning the of week 9/23/15, members of the IDT Management will conduct interviews of 5 current residents and compile the findings weekly for 4 weeks then monthly for 2 months, to verify residents' feelings of treatment with dignity by staff.</p> <p>A member of the QAPI Leadership Team will meet with Resident Council Monthly to receive their input regarding these audit results. Findings will be investigated further by members of the social services department to allow for further re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor</p>		

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F 241  F 252 SS=E	<p>Continued From page 3</p> <p>On 7/17/15 at 6:30 PM, the Administrator, DNS and MCO were informed of the issues.</p> <p><b>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b></p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure residents could enjoy a homelike environment which was free of unsightly weeds, a shed in disrepair and clear windows. This was true for 1 of 1 outside courtyards and 1 of 3 common areas in the east wing. The deficient practice had the potential for psychosocial harm for those living in an unappealing environment, or who did not have a clear view to the outside. Findings included:</p> <p>A. On 7/14/15 at 10:12 AM, several residents were observed finishing an activity in the facility's outside courtyard and being escorted back inside the facility. In the courtyard, two large raised flower beds were observed with numerous unsightly weeds, which overwhelmed most of the beds. The courtyard also contained a large wooden shed with a one-foot by six-inch section of rotted exposed wood with peeling paint to the lower front side.</p> <p>B. On 7/14/15 at 11:57 AM, two upper windows in the 400 common room/library were observed</p>	F 241  F 252	<p>root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/2015</p> <p><b>F252 RESIDENT SPECIFIC</b> Courtyard – The courtyard weeds were addressed and the shed siding was replaced to achieve a homelike standard, on or before 9/23/15.</p> <p>400 Hall Common Area – A purchase order for the replacement of the windows identified in the common area with broken seals was signed on or before 9/23/15.</p> <p><b>OTHER RESIDENTS</b> Members of the Interdisciplinary Team completed environmental audits to address cleanliness and maintenance in common areas as well as resident rooms</p>	

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F 252	<p>Continued From page 4</p> <p>covered with condensation build-up between the panes of glass, which made the windows appear fuzzy and difficult to see through.</p> <p>On 7/16/15 from 9:30 AM to 10:15 AM, during the environmental tour, the Maintenance Assistant was shown the condensation in the library windows. During that time only the window to the left had condensation in it. He said the windows had lost their seal and needed to be replaced. When shown the courtyard shed, the Maintenance Assistance said the condition of the shed was "bad" and in need of repair. When shown the weeds in the flower bed, he said activity staff were responsible for the maintenance of the bed.</p> <p>On 7/16/15 at 2:40 PM, the Activity Director was shown the flower beds and acknowledged she was aware her department was responsible for the flower bed upkeep. She stated, "There are weeds in there, yes."</p> <p>On 7/16/15 at 5:10 PM, the Administrator, DNS and MCO were informed of the issues.</p> <p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, Resident Council minutes, resident group interview, and staff interview, it was determined the facility failed to</p>	F 252	<p>on or before 9/23/15. Identified concerns were addressed at time of discovery.</p> <p><b>FACILITY SYSTEMS</b> The Maintenance Director and the Director of Housekeeping were educated by the administrator on or before 9/23/15 regarding the expectations of compliance under F252 including the cleanliness and maintenance expectations for the center. Preventive Maintenance schedules and cleaning schedules were reviewed for effectiveness and updated as necessary.</p> <p><b>MONITORS</b> Beginning the week of 9/23/15 the Maintenance Director and the Housekeeping Director, or designees, will each audit three resident rooms or common areas per side of the building per week for one month and then one room or common area per side of the building for two months to ensure that there are no unaddressed Housekeeping or Maintenance issues.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p>	
F 253 SS=E		F 253		

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F 253	<p>Continued From page 5</p> <p>ensure:</p> <ul style="list-style-type: none"> <li>*A toilet was cleaned in Resident #8 and #9's bathroom;</li> <li>*The floor was cleaned in the 100 hallway common area;</li> <li>*Trash was picked up outside of the 100 hallway exit;</li> <li>*The shower stall floor in the 100 hallway was cleaned;</li> <li>*Carpets in the 200 and 400 hallways were free of foul smells and stains;</li> <li>*Hand sanitizer dispensers, fire extinguisher boxes, thermostat covers, and a paper towel dispenser in the 100 and 400 hallways and East Wing dining room were free of dust and grease build-up;</li> <li>*A smoking apron in the East Wing smoking area was free from stains; and,</li> <li>*A refrigerator in Resident #1's room was free from spilled liquids, expired food, and temperatures were documented. This had the potential to affect the quality of life for residents residing or frequenting these areas. Findings included:</li> </ul> <p>1. On 7/13/15 at 11:10 AM and at 1:48 PM, the bathroom toilet seat riser in Resident #8 and #9's room was observed with a four-inch by three-inch area of dried urine residue and a small area of dried feces on the inside of the seat riser.</p> <p>On 7/13/15 at 1:45 PM, Housekeeper #8 was observed near Resident #8 and #9's room. He stated the room and bathroom had already been cleaned that day.</p> <p>On 7/13/15 at 2:10 PM, the Director of Environmental Services (DES) was shown the toilet seat riser in the bathroom. He said, "I see</p>	F 253	<p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/2015</p> <p><b>F253</b> <b>RESIDENT SPECIFIC</b></p> <p>Resident #1's personal fridge was cleaned on 7/17/15 by The Senior Director or Dining Services. The temperature was also checked on 7/17/15 by The Senior Director of Dining Services to assure the temperature was in parameters.</p> <p>Resident #8 and resident #9's bathroom was cleaned on 7/13/15 by Housekeeping to assure bathroom was free of bodily fluids.</p> <p>100 Hall Common Area was cleaned on 7/14/15 by a Housekeeper to remove the 15 pieces of popcorn and small pieces of plastic debris.</p> <p>100 Hall Shower Room was cleaned on 7/13/15 by housekeeper to remove debris noted by surveyor.</p>

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F 253	<p>Continued From page 6</p> <p>feces, it needs to be removed and [the] urine, as well."</p> <p>2. On 7/13/15 at 11:28 AM, 12:56 PM, 2:52 PM, 3:42 PM, and on 7/14/15 at 9:30 AM, the 100 hallway common area was observed with 15 pieces of popcorn and small pieces of plastic trash scattered on the floor. There were no scheduled activities in that room for the morning of 7/13/15.</p> <p>On 7/14/15 at 2:45 PM, the DES was interviewed in the common area, which no longer exhibited popcorn and debris on the floor. When asked about the common room vacuum schedule, he said the room should be vacuumed every morning and that he had "no idea" why the room was not vacuumed the previous day.</p> <p>3. On 7/13/15 at 11:28 AM, 12:56 PM, 2:52 PM, 3:42 PM, and on 7/14/15 at 9:30 AM and 11:43 AM, a discarded plastic shopping bag and used napkin was observed outside through the window next to the exit door near the 100 hallway common area.</p> <p>On 7/14/15 at 2:45 PM, the DES, when shown the trash, stated the maintenance department was responsible for cleaning the outside of the building. He opened the door, picked up the trash, and threw it away.</p> <p>4. On 7/13/15 at 1:05 PM, the 100 hallway shower room was observed with the DNS present. On the shower stall floor was a small empty pepper packet and several small rocks, small pieces of what appeared to be tile grout and a gritty dirt material. When asked why there was debris in the shower stall, she stated, "I will get</p>	F 253	<p>400 Hall Carpet – A purchase order to replace the carpet was signed on or before 9/23/15.</p> <p>200 Hall Carpet - A purchase order to replace the carpet was signed on or before 9/23/15.</p> <p>100 Hall – Housekeeping dusted the hall 7/13/15</p> <p>400 Hall - Housekeeping dusted the hall 7/13/15</p> <p>East Wing Dining Room – The paper towel dispenser was cleaned by the Director of Environmental Services on 7/13/15.</p> <p>Smoking Aprons – The smoking aprons were cleaned by the Director of Environmental Services on or before 7/17/15.</p> <p><b>OTHER RESIDENTS</b></p> <p>An audit of patient care areas was completed by the Director of Maintenance and the Director of Housekeeping on or before 9/23/15 and identified issues were corrected on or before 9/23/15.</p> <p>An audit of residents with personal fridges was completed on or before 9/23/15 by members of the Interdisciplinary Team to assure temperature logs were current, expired items were removed and fridge</p>	

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NAME OF PROVIDER OR SUPPLIER  APEX CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704		
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F 253	<p>Continued From page 7</p> <p>housekeeping in here immediately." She said the shower should be cleaned after each resident use.</p> <p>On 7/14/15 at 1:30 PM, during the Resident Group interview, 4 of 5 residents stated the 100 shower room smelled of foul odors and needed to be cleaned better. One resident said a few weeks prior, before receiving a shower in the 100 shower room, he/she observed used towels "all over the floor" which the CNA assisting him/her "kicked out of the way" rather than place them in the soiled linen container. The resident also stated the CNA failed to sanitize the floor prior to his/her shower that day.</p> <p>5. On 7/13/15 at 1:44 PM, the 400 hallway carpet was noted to emit a urine odor. On 7/15/15 at 1:20 PM, the hallway carpet near room 415 was also noted with musty and urine odors.</p> <p>On 7/14/15 at 1:30 PM, during the Resident Group interview, 4 of 6 residents stated the East Wing carpets had old stains and smelled, even after they had been cleaned.</p> <p>On 7/15/15 at 2:05 PM, the hallway carpet near room 202 was observed with a three-foot by two-foot dried stain.</p> <p>On 7/16/15 from 9:30 AM to 10:15 AM, during the environmental tour, the Maintenance Assistant (MA) and the DES were shown the carpet stain on the 200 hallway carpet, which they said would be cleaned. At the time of the tour, the carpet in the 400 hallway did not have a foul smell, but both were informed of the issue.</p> <p>6. On 7/14/15 from 4:40 PM to 4:50 PM, hand</p>	F 253	<p>was clean. Any identified concerns were corrected at time of review.</p> <p><b>FACILITY SYSTEMS</b></p> <p>The Maintenance Director and the Director of Housekeeping were educated by the administrator on or before 9/23/15 regarding the expectations of compliance under F253 including the cleanliness and maintenance expectations for the center.</p> <p>Nursing staff were educated on or before 9/23/15 by Nurse Practice Educator or designee regarding personal fridge use and maintenance expectations. Nursing staff will now record temperature, check for expired items requiring removal and assure cleanliness daily.</p> <p>Preventive Maintenance schedules and cleaning schedules were reviewed with the facility Administrator and Regional Support Staff for effectiveness and updated as necessary on or before 9/23/15.</p> <p><b>MONITORS</b></p> <p>Beginning the week of 9/23/15 the Maintenance Director and the Housekeeping Director, or designees, will each audit three resident rooms or common areas per side of the building per week for one month and then one room or common area per side of the building for two months to ensure that there are no unaddressed Housekeeping or Maintenance issues.</p>		

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	<p>Continued From page 8</p> <p>sanitizer dispensers, fire extinguisher boxes, thermostat covers were observed to have dust build-up in the 100 and 400 hallways and East Wing dining room. Grease build-up was also observed on top of the paper towel dispenser in the East Wing dining room.</p> <p>On 7/15/15 at 2:30 PM, the DES was shown the dust on the various items. From a distance of more than 10 feet, the DES stated, "I see it," when shown the grease on the paper towel dispenser.</p> <p>7. On 7/14/15 at 5:22 PM, 1 of 2 smoking aprons near the East Wing smoking area was observed soiled with an unknown substance and marked with numerous stains.</p> <p>On 7/16/15 from 9:30 AM to 10:15 AM, when shown the apron, the MA said, "It's due for a cleaning."</p> <p>8. On 7/13/15 at 10:35 AM, 11:30 AM, 12:40 PM, and 2:00 PM, a small refrigerator in Room 101, shared by Resident #1 and Resident #32, was observed with two dried red fruit punch stains, approximately 2 inches in size, along with multiple splatter stains on the bottom left hand shelf. Directly above the stains on the top shelf was an partially consumed 1-gallon jug of red fruit punch drink laying on its side. On the bottom shelf was a slice of strawberry swirl cheesecake encased in a clear plastic case with a use by date of 7/13/15. The door of the refrigerator contained a Temperature Record (TR) for the month of July with documented temperature readings of 36 Degrees F (Fahrenheit) for July 1 - 7. The TR did not document temperature readings after July 7.</p>		<p>Beginning the week of 9/23/15 members of the Interdisciplinary Team will complete five time weekly audits for 4 weeks then weekly for 2 months to assure residents' personal fridges are current with temperature recordings, clean and free from expired or outdated items.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 253	<p>Continued From page 9</p> <p>On 7/13/15 at 2:45 PM, a CNA was observed answering Resident #1's call light. The resident asked for some fruit punch with ice and cheesecake, which the CNA provided from the resident's refrigerator. The CNA did not clean the spills and stains visible on the bottom shelf.</p> <p>On 7/14/15 at 9:45 AM, 11:40 AM, 1:30 PM, and 4:30 PM, the refrigerator was observed with two fresh red fruit punch stains approximately 2" in size on top of the dried stains on the bottom shelf of the refrigerator. The cheesecake with the use by date of 7/13/15 was on the bottom shelf, and approximately 1/4th of the slice had been eaten. The TR documented a temperature of 40 Degrees F (Fahrenheit) for 7/14/15.</p> <p>On 7/14/15 at 4:30 PM, Resident #1 stated, "Housekeeping doesn't clean the refrigerator and neither do the CNA's." Resident #32 stated, who was also in the room at the time, stated, "My daughter usually cleans it when she comes in, but she hasn't been in lately."</p> <p>On 7/14/15 at 4:45, CNA #9 stated kitchen staff usually cleaned resident room refrigerators, but that he would clean those areas and items he saw needed it.</p> <p>On 7/15/15 at 7:25 AM, the refrigerator in Room 101 was observed still containing the red fruit juice stains and splatter on the bottom left hand shelf. A new, unopened 1 gallon red fruit juice jug was observed on the top shelf directly above the juice stains laying on its side. The cheesecake, with the use by date of 7/13/15, remained on the bottom shelf.</p>	F 253		

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

PRINTED: 09/24/2015  
FORM APPROVED  
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F 253	<p>Continued From page 10</p> <p>On 7/15/15 at 7:30 AM, Unit Manager (UM) #10 observed the refrigerator in Room 101 and stated there was a spill of red fruit punch on the bottom shelf. She stated housekeeping staff were responsible to keep the refrigerators clean, however any staff member who saw areas in the refrigerator in need of cleaning would be responsible for doing so. She stated housekeeping was also responsible for documenting refrigerator temperatures and were to check the "use by" dates on food items. UM #10 stated, "It is obviously pretty clear they haven't taken the temperature from 7/7 to 7/14/15."</p> <p>On 7/15/15 at 1:55 PM, the Director of Environmental Services stated housekeeping staff were responsible for cleaning resident room refrigerators, checking and posting temperatures on the TR, and checking food items' "use by" dates. He stated he was notified by UM #10 that morning that the refrigerator in Room 101 needed cleaning, which was completed at 10:00 AM.</p> <p>On 7/17/15 at 6:30 PM, the Administrator and DON were made aware of the resident room refrigerator concerns.</p>	F 253		
F 254 SS=E	<p>483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION</p> <p>The facility must provide clean bed and bath linens that are in good condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, Resident Group interview, and staff interview, it was determined</p>	F 254	<p>F254 RESIDENT SPECIFIC On or before 9/23/15, affected linens were removed by Director of Housekeeping from the 100, 200, 500, and 600 hall linen closets.</p>	

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F 254	Continued From page 11 the facility failed to ensure bath linens were in good condition for the residents. This was true for 4 of 5 linen rooms examined (100, 200, 500 and 600 hallways) and had the potential to adversely affect residents sense of self worth when using frayed and rough bath linens. Findings included:  On 7/14/15 at 1:30 PM, during the Resident Group interview, one resident said the "linens are almost like rags." Another resident said bath towels were rough and had holes.  On 7/15/15 from 1:45 to 1:55 PM, one washcloth and one body towel in each of the clean linen closets of the 100 and 200 hallway were observed to be frayed.  On 7/15/15 at 2:10 PM, the DNS and Unit Manager #12 were shown the frayed washcloth and body towel in the 200 hallway linen closet and informed the 100 hallway had similar examples. The DNS stated the washcloth and body towels were frayed and that while CNAs should not use frayed and/or worn washcloths or towels for resident cares, it was laundry staff who were responsible for the disposing of frayed linens.  Similar findings were observed in the 500 and 600 hallway linen closet.  On 7/16/15 at 5:10 PM, the Administrator, DNS and MCO were informed of the issues.	F 254	<b>OTHER RESIDENTS</b> An inventory of all linen was completed by the laundry supervisor on or before 9/23/15 to ensure that all linen was free of any fraying or holes. Linens were discarded as indicated at time of review and replacement linens were ordered.  <b>FACILITY SYSTEMS</b> Environmental Services supervisor was educated by center administrator on or before 9/23/15 regarding the standard of linens expected and other areas that pertain to F254.  On or before 9/23/15 the Environmental Services supervisor or designee educated laundry staff on the linen quality assessment process and will complete a monthly inventory of linens to ensure integrity of material and that they are free of any fraying or holes prior to stocking on the resident care units.  <b>MONITORS</b> Members of the IDT management will audit center linen closets weekly for four weeks and then monthly for 2 months to ensure linens are free of frays and holes.  The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	<p>Continued From page 12 comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined the facility failed to ensure all areas triggered by the RAI process and/or individualized behavior interventions were care planned. This was true for 5 of 23 residents' care plans (#1, #5, #6, #7, &amp; #21). The failure created the potential for unmet needs when there was no visionary care plan for Resident #7 and no individualized behavioral directions in the care plan for residents #3, #5, #6, and #21. Findings include:</p> <p>1. Resident #5 was admitted to the facility 5/12/14 with multiple diagnoses, including bipolar disorder, depression, anxiety, dementia, and schizoaffective disorder.</p>	F 279	<p>will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p>Date of Compliance 9/23/15</p> <p><b>F279</b> <b>RESIDENT SPECIFIC</b> Resident #1 discharged on 7/30/2015 and is no longer a resident in this facility.</p> <p>Resident #3's behavioral care plans were updated by LSW or designee on or before 9/23/15 to reflect interventions on the Sol-Oasis resident needs monitoring sheets.</p> <p>Resident #5 behavioral care plans were updated by LSW or designee on or before 9/23/15 to reflect interventions on the Sol-Oasis resident needs monitoring sheets.</p> <p>Resident #6 behavioral care plans were updated by LSW or designee on or before 9/23/15 to reflect interventions on the</p>	

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F 279	<p>Continued From page 13</p> <p>The 6/11/15 Behavior Care Plan documented the resident "exhibits behavior of tearfulness and negative statements..." Interventions (all initiated 9/30/15) included:                      *"Allow resident time to vent feelings/needs;                      *Approach resident in a calm and friendly manner;                      *Divert resident by giving alternative objects or activity;                      *Encourage and teach resident calming techniques;                      *Encourage resident to attend activities of choice and adjust time spent on resident's tolerance and attention span; and,                      *Resident continues to be seen by Geriatric Psychiatrist."                      The care plan also documented the specific [behavioral unit] programs in which the resident should be encouraged to participate.</p> <p>The 5/9/15 Resident Need Monitoring documented the following individualized interventions for specific behaviors:                      *"I have been known to have paranoid thoughts and/or hallucinations.                      *Please listen to me. Sometimes the things I say may seem difficult to comprehend but please be respectful in our interaction.                      *Please let my nurses know I am having some difficulties."</p> <p>On 7/16/15 at 10:05 a.m., UM #12 was asked about individualized behavior interventions in the care plan and said, "Yes, they [the Resident Need Monitoring interventions] could be crossed over."</p> <p>2. Resident #21 was admitted 10/8/13 with multiple diagnoses including major depressive disorder and anxiety.</p>	F 279	<p>Sol-Oasis resident needs monitoring sheets.</p> <p>Resident #7 care plans were updated by RN Unit Manager on or before 7/31/15 to reflect interventions to address vision needs.</p> <p>Resident #21 behavioral care plans were updated by LSW or designee on or before 9/23/15 to reflect interventions on the Sol-Oasis resident needs monitoring sheets.</p> <p><b>OTHER RESIDENTS</b>                      Members of the clinical interdisciplinary team completed an audit of residents who currently reside in the facility to verify comprehensive care plans have been developed to meet individualized needs on or before 9/23/15. Identified concerns were corrected by members of the nurse management team on or before 9/23/15.</p> <p><b>FACILITY SYSTEMS</b>                      Individuals involved in the Care-Planning process will receive re-education regarding importance of developing comprehensive care plans to reflect individualized needs of residents as well as meeting the other requirements under F279 on or before 9/23/15. The Sol-Oasis Resident Needs Monitor will be correlated with the behavior care plans through the care planning process and will continue to be a permanent part of the resident record.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	<p>Continued From page 14</p> <p>The 7/8/15 Behavior care plan documented the resident exhibited statements of negative feelings, refused cares, and yelled into hallways. Interventions (all initiated 12/14/14) included:            *"Allow resident to vent feelings/needs;            *Approach resident in a calm friendly manner;            *Divert resident by giving alternative objects or activity; and,            *Encourage and teach resident calming techniques."            The care plan also documented the specific [behavior unit] programs in which the resident should be encouraged to participate.</p> <p>The 9/18/14 Resident Needs Monitor documented individualized interventions for specific behaviors:            *"[Resident #21] has been known to call out for assistance;            *Encourage [Resident #21] to utilize her call light. She has a touch pad for ease of use...            *[Resident #21] has been known to see or hear things tht are not actually present; reassure her that these things are not in the room and she is safe.            *[Resident #21] prefers to spend time in bed;            *Spend one on one time with her. She enjoys visiting and having you read aloud.            *[Resident #21] enjoys root beer and lemonade."</p> <p>On 7/16/15 at 10:05 a.m., UM #12 was asked about individualized behavior interventions in the care plan and said, "Yes, they [the Resident Need Monitoring interventions] could be crossed over."</p> <p>On 7/17/15 at 6:30 p.m., the Administrator and DON were notified of these issues.</p>	F 279	<p><b>MONITORS</b>            Beginning of week 9/23/15, members of the clinical interdisciplinary team will conduct an audit of 8 current residents and compile the findings weekly for 4 weeks then monthly for 2 months, to ensure that comprehensive care plans have been developed that reflect individualized resident needs based upon the CAA triggers and, as appropriate, are correlated with the Sol-Oasis Resident Needs Monitor form. Findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p>	

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F 279	Continued From page 15  3. Resident #7 was admitted to the facility on 12/24/14 with diagnoses of rehabilitation, encephalopathy, major depression, and pneumonitis.  The resident's Admission MDS Assessment, dated 12/31/14, documented in Section V a care planning decision for the problem of Visual Function. Additionally, the MDS coded the resident was moderately cognitively impaired with a BIMS score of 9.  The resident's CAA (Care Area Assessment) worksheet for the 12/31/14 ARD (Assessment Reference Date) documented, "Rt.[Right] eye enucleation [removal of the eye that leaves the eye muscles and remaining orbital contents intact] and tracks with decreased vision in lt.[left] eye. Chronic traumatic deformity of the rt. orbit and optic globe."  Resident #7's Care Plan (CP) was reviewed for the MDS triggered problem of visual function, which was not included in the resident's care plan.  On 7/15/15 at 3:25 PM, UM #10 stated, "No, there isn't a Visual Care Plan, not that I can see."  4. Resident #1 was admitted to the facility on 6/25/09, and readmitted on 6/25/15, with diagnoses including paraplegia, Hodgkin's Disease, and malignant lymphomas.  The resident's most recent 6/25/15 Admission MDS Assessment was still in progress during the survey week of 7/13/15. The resident's most	F 279	Date of Compliance 9/23/15		

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

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F 279	<p>Continued From page 16</p> <p>recent Annual MDS Assessment, dated 6/26/14, and most recent Quarterly MDS Assessment, dated 5/25/15, both documented the resident was cognitively intact with a BIMS Score of 15 and was always incontinent of urine. Additionally, the Annual MDS Assessment documented in Section V a care planning decision for the problem of urinary incontinence.</p> <p>The 6/26/14 MDS triggered problem of urinary incontinence was not addressed in Resident #1's care plan, except for a single intervention in the resident's skin integrity care plan of 1/9/15.</p> <p>On 7/16/15 at 2:55 PM, UM #10 stated Resident #1 was always incontinent and a care plan should have been developed.</p> <p>On 7/17/15 at 6:30 PM, the Administrator and DON were made aware of care plan concerns.</p> <p>5. Resident #6 was admitted to the facility on 5/13/15 with multiple diagnoses, including severe alcohol abuse, essential hypertension, cystitis, bacteremia with sepsis, bladder neck obstruction, and GERD (Gastroesophageal Reflux Disease).</p> <p>Resident #6's Care Plan, updated on 6/11/15, documented:</p> <ul style="list-style-type: none"> <li>* Focus area - Discharge, Anticipate stay of less than 90 days (Created on 5/14/15).</li> <li>* Approaches included - <ul style="list-style-type: none"> <li>- Ascertain learning level and establish teaching needs,</li> <li>- Provide education plan specific to resident needs,</li> <li>- Provide clear expectations and feedback,</li> </ul> </li> </ul>	F 279		

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F 279	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>- Medication teaching and self-administration program,</li> <li>- Regularly assess discharge potential and keep resident updated,</li> <li>- Schedule a resident/family meeting to explore resident's functional level for discharge.</li> </ul> <p>Resident #6's Care Plan was not updated to include:</p> <ul style="list-style-type: none"> <li>* The resident's learning level and his specific teaching needs to ensure a successful return to the community,</li> <li>* A comprehensive, individualized education plan to meet the identified needs,</li> <li>* A medication teaching plan and goals/objectives moving towards his self-administration of medication.</li> </ul> <p>In addition, the resident's care plan did not identify what physical and/or psychosocial interventions should be implemented in anticipation for an upcoming surgery scheduled for 7/27/15.</p>	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in</p>	F 280	<p><b>F280 RESIDENT SPECIFIC</b></p> <p>Resident #4 was discharged on 8/10/2015 and is no longer a resident in this facility. Resident #7's care plan addressing skin integrity was reviewed and updated by RN Unit Manager or designee on or before 7/31/15 to reflect the resident's interventions that are utilized currently by resident and discontinuation of tubigrips.</p> <p>Additionally, resident #7's nutrition care plan and care plan addressing activities of daily living was reviewed on or before 7/31/15 by RN Unit Manager or designee</p>	

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

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 280	<p>Continued From page 18</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to review and revise care plans for 2 of 19 sampled residents (#s 4 &amp; 7). Resident #4's Nutrition Care Plan did not include specific interventions related to speech therapy recommendations for eating solid foods, offering additional food when meal intake was decreased, and high caloric interventions. Resident #7's Nutrition Care Plan was not revised to reflect the resident was independent and no longer needed supervision, cueing and/or assistance with meals. Additionally, Resident #7's care plan for skin integrity were not revised as the resident no longer wore geri-sleeves or tubi-grips. This had the potential for harm if residents did not receive appropriate care due to lack of direction in the care plan. Findings included:</p> <p>1. Resident #7 was admitted to the facility on 12/24/14 with diagnoses including rehabilitation, encephalopathy, and pneumonitis.</p> <p>The resident's most recent Quarterly MDS Assessment, dated 6/30/15, documented the resident was cognitively intact with a BIMS Score of 15, independent, and needed setup help only</p>	F 280	<p>and updated to reflect the resident's current required assistance with meals.</p> <p><b>OTHER RESIDENTS</b> Members of Clinical Interdisciplinary Team completed an audit of residents who currently reside in the facility to assure their care plan accurately reflected the resident's current plan of care related to their current condition including therapy recommendations and identified concerns were corrected by members of the Clinical Interdisciplinary Team on or before 9/23/15.</p> <p><b>FACILITY SYSTEMS</b> Members of the Clinical Interdisciplinary Team including the skilled therapy team will receive re-education by the Nurse Practice Educator on or before 9/23/15 on the requirements of compliance with F280 including the importance of communicating therapy and dietary recommendations as well as updating of care plan current to the resident's condition, utilized interventions and preferences.</p> <p>Therapy and Dietary recommendations will be reviewed in the facility's morning clinical meeting to assure resident's plan of care is updated and communicated to direct care staff on or before 9/23/15.</p> <p><b>MONITORS</b> Beginning of week 9/23/15, members of the Clinical Interdisciplinary Team will</p>	

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F 280	<p>Continued From page 19 for eating.</p> <p>a. The resident's 6/30/15 Nutritional Assessment documented, "Independent eater in DR [Dining Room] with set-up and intermittent supervision."</p> <p>Resident #7's Nutrition Care Plan, initiated 12/29/14 and revised 6/30/15, documented an intervention, initiated 1/15/15, to "supervise/cue/assist as needed with meals."</p> <p>On 7/15/15 at 3:25 PM, UM #10 stated, "That intervention shouldn't be on there, there is no reason for it to be there."</p> <p>b. The resident's care plan for the focus of skin integrity, initiated 2/4/15 and revised 7/8/15, documented the following interventions: **"Use tubi-grips [geri-sleeves] as ordered to BUE [bilateral upper extremities]," initiated 2/4/15; and, **"Tubi-grips to BLE [bilateral lower extremities] as he allows," initiated 2/6/15.</p> <p>The resident was not observed wearing geri-sleeves or tubi-grips on his arms or legs during the survey week of 7/13 through 7/17/15.</p> <p>On 7/15/15 at 7:30 AM, Resident #7 stated he hadn't worn tubi-grips on his arms or legs for two months because it made him itch.</p> <p>On 7/15/15 at 3:25 PM, UM #10 stated she had discussed discontinuing the order for geri-sleeves or tubi-grips with the nurses on the floor since the resident didn't like to wear them and that the care plan should have been revised since he wasn't wearing them.</p> <p>On 7/17/17 at 6:30 PM, the Administrator and</p>	F 280	<p>conduct an audit of 5 current residents and compile the findings weekly for 4 weeks then monthly for 2 months, to ensure that resident's careplan is current to the resident's condition, utilized interventions and preferences. Findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p>	

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

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F 280	<p>Continued From page 20</p> <p>DON were made aware of the care plan concerns.</p> <p>2. Resident #4 was admitted to the facility 11/14/15 with multiple diagnoses including dementia and dysphagia.</p> <p>The July 2015 ADL Care Plan documented the resident required extensive assistance with eating (initiated 11/20/14). The Nutrition Care Plan (initiated 11/21/14) documented the resident was at nutritional risk related to "poor intake-dysphagia, decreased cognition-decline..." and documented the following interventions:                      *Honor food preferences within meal plan [initiated 11/21/14];                      *Provide small portions [initiated 11/21/14];                      *Monitor for changes in nutritional status (change in intake, ability to feed self, unplanned weight loss/gain...) [initiated 11/21/14];                      *Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake [initiated 11/21/14];                      *Provide diet as ordered [initiated 11/21/14];                      *House supplement as ordered [initiated 11/21/14];                      *Encourage patient to come to dining room for meals [initiated 11/21/14];                      *Offer/encourage fluids of choice [initiated 1/13/15];                      *Weight monthly and alert dietitian and physician to any significant loss or gain [initiated 3/31/15].</p> <p>a. Resident #4's 4/22/15 Speech Therapy Discharge Summary documented, "Puree texture remains the safest and most efficient diet for this resident; however, she can tolerate dysphagia</p>	F 280			

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F 280	<p>Continued From page 21</p> <p>advanced items on special occasions (i.e. cake with activities) with supervision, setup, and ample time. Setup should include cutting items into small pieces and/or adding moisture to dry items; supervision should include watching for pocketing or inability to chew a bite after a while, then she should be encouraged to drink liquids and/or spit the item out to avoid choking hazard. Resident should be routinely encouraged to alternate liquids and solids with all po [oral] intake."</p> <p>Note: The speech therapy recommendations were not in the care plan. Refer to F309 regarding issues with communication of these recommendations to the entire care team.</p> <p>On 7/16/15 at 9:00 a.m., when asked if the speech therapy recommendations were communicated in the resident's care plan, UM #10 stated, "No, they're not always in the care plan."</p> <p>b. The June 2015 Physician Recapitulation orders for Resident #4 documented:                  *"Chart amount of meals taken, if 50% of meal not consumed offer substitution [initiated 11/14/14];                  *Weigh every day shift every 1 month on the 1st day... [initiated 12/1/14];                  **Regular/liberalized diet, dysphagia puree texture, thin liquids [initiated 1/12/15];                  *House supplement with meals [initiated 6/16/15]."</p> <p>On 7/17/15 at 8:45 a.m., the dietician was interviewed about Resident #4's significant weight loss in June (refer to F325). She confirmed the intervention to offer substitution for decreased meal intake (less than 50%) was not documented</p>	F 280			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 23</p> <p>documentation that the facility had attempted to contact the surgeon to clarify the precautions.</p> <p>On 5/5/15, the Physical Therapist provided the following education and instruction to the resident and his family members: Do not cross legs; staff to transport resident via wheelchair to and from the dining room; and no vigorous exercises for one hour following meals.</p> <p>The Cardiac care plan, dated 5/7/15, documented, "Resident will be encouraged to follow sternal precautions - encourage to not bear weight in arms" and which specific precautions and/or activities to avoid.</p> <p>The ADL record for May 2015 documented, on 5/4, 5/5, 5/6, 5/7, 5/8 day shift, 5/5 and 5/7 evening shift, and 5/4 night shift that the resident propelled himself independently in his wheelchair on/off the unit.</p> <p>On 7/15/15, when asked, the ADON stated the Therapy Department was responsible for clarifying Resident #18's sternal precautions upon admission.</p> <p>On 7/15/15 the Therapy Director stated nursing staff should know what Resident #18's sternal precautions were and that the surgeon should be contacted with any requested clarifications. The Therapy Director stated, "It is not the therapy department's responsibility to instruct the nursing staff on sternal precautions and/or to clarify the order."</p> <p>On 7/15/15, when asked if the facility clarified Resident #18's sternal precautions with the surgeon, the DNS stated, "No, and we would not</p>	F 309	<p>On or before 9/23/15 members of the IDT have received education from the Nurse Practice Educator or designee on the importance of clarifying orders as necessary and on ensuring effective communication within the facility; as well as other components required under F309 to ensure patient care is delivered in an effective and coordinated manner to attain or maintain the highest practicable physical, mental, and psychosocial well-being of our patients and/or residents in accordance with the comprehensive assessment and plan of care The education was provided by the Director of Nursing and Rehab Manager or designees on or before 9/23/15.</p> <p><b>MONITORS</b> Beginning the of week 9/23/15, Nurse Managers will conduct an audit of 5 new admissions or residents with precaution orders or a change in condition and complete the findings weekly for 4 weeks then monthly for 2 months, to ensure that clarification for precautions is coordinated and presented in a timely manner.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and</p>		

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F 309	Continued From page 24 call to clarify unless the resident experienced complications." The DNS stated the therapy department determines the precautions and then notifies the nursing staff. The DNS was unable provide documentation that sternal precautions had been implemented and monitored for Resident #18.  On 7/17/15, the Administrator and DNS were informed of the concern.	F 309	performance improvement plans as indicated.  Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the OAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.		
F 322 SS=0	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that --  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on observation and policy review, it was	F 322	Date of Compliance 9/23/15  F322 RESIDENT SPECIFIC Resident #28 had an assessment for adverse effects related to medication being administered completed on or before 7/22/15 by a licensed nurse. No adverse effect was noted upon assessment.  LN #2 completed a medication administration competency administered by a nurse manager that included medication via PEG tube on or before 9/23/15. Re-education was provided as indicated at time of competency.  OTHER RESIDENTS Medication administration competencies for licensed nurses caring for residents with PEG tubes will be administered by		

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F 322	<p>Continued From page 25</p> <p>determined the facility failed to ensure there was correct placement of a PEG (percutaneous endoscopic gastrostomy) tube prior to the administration of medications. This affected 1 of 2 residents (#28) during PEG medication administration pass observations. This failure created the potential for the resident to experience gastrointestinal distress and/or aspiration pneumonia and receive less than optimal benefit of the medications administered. Findings included:</p> <p>Resident #28 was admitted to the facility on 7/7/15 with multiple diagnoses, including cerebrovascular accident (CVA), hemiplegia, dysphagia, pneumonia, and a newly placed PEG tube.</p> <p>Resident #28's physician's order, dated 7/15/15, documented: "Check tube for proper placement prior to each feeding, flush for medication administration." An interim physician's order, dated 7/16/15, documented: "NPO: [nothing by mouth] All meds to be given via peg tube only. Resident is strict NPO every shift."</p> <p>The facility's Enteral Medication Administration Policy, with an effective date of 1/1/04 and revision date of 1/2/14, documented: "Verify tube placement ... Place stethoscope over patient's epigastric region. Inject 10 ml air into tube while listening for whooshing sound ... Check for residual by using syringe to ... Aspirate stomach contents ... Measure amount of residual ..."</p> <p>On 7/17/15 at 9:15 am, LN #2 was observed as she flushed the resident's PEG with 30 ml of tap water prior to the administration of the crushed medications. The LN did not take a stethoscope</p>	F 322	<p>the Nurse Practice Educator or designee on or before 9/23/15.</p> <p><b>FACILITY SYSTEMS</b> Licensed Nurses will be educated on nasogastric and gastrostomy tube management, including medication administration and other requirements under F322 by the RN, Nurse Practice Educator or designee on or before 9/23/15.</p> <p>Medication administration competencies including how to properly administer medications through a PEG tube will be administered by the Nurse Practice Educator or designee on or before 9/23/15 to Licensed Nurses to identify deficient practice and the need for ongoing individual education.</p> <p><b>MONITORS</b> Beginning the week of 9/23/15, the Nurse Practice Educator or designee will repeat a medication administration competency including administration of medications through a PEG tube with Licensed Nurses 5 times a week for 2 weeks, then 3 times a week for 2 weeks then twice a week for 2 months.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for</p>	



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F 323 Continued From page 27  
threshold had gaps which had the potential to cause a trip hazard. Findings included:

1. On 7/14/15 at 5:22 PM, 1 of 2 smoking aprons near the East Wing smoking area was observed to have at least 8 slits in the apron which ranged from one-inch to six-inches in length. The slits were large enough to allow hot ash through them.  
  
On 7/16/15 from 9:30 AM to 10:15 AM, during the environmental tour, the MA [Maintenance Assistant] was shown the apron. The MA stuck his finger through one of the holes and said, "This shouldn't even be up here."
2. On 7/14/15 at 10:12 AM, a raised flower bed in the courtyard was observed. The bed was constructed of wood composite material and appeared to have a board missing. The board which would have been tied into the missing board had three exposed screws, with the sharp pointed ends protruding from it.  
  
On 7/16/15 from 9:30 AM to 10:15 AM, during the environmental tour, the MA was shown the board with the sharp screws and he said, "It needs to be taken care of."
3. On 7/14/15 at 11:59 AM, the hard plastic threshold on the ground between the carpet in the 400 hallway and the hard surface floor in the facility's building bridge was observed. Two feet of the threshold was cracked and a one-foot by a half-inch section was missing, which created a gap between the carpet and the threshold where residents could trip.

F 323 Environmental rounds were completed on or before 8/30/15 by members of the IDT to identify safety hazards. Identified concerns were corrected on or before 9/23/15 by the Maintenance Director or designee.

**FACILITY SYSTEMS**  
Facility Staff have been re-educated on communicating identified potentially hazardous findings to maintenance director for repair in the Maintenance Log.  
  
The Maintenance Director was re-educated by the Administrator on or before 9/23/15 on the identification and correction of safety hazards to ensure that the environment presents no preventable risks.  
  
Smoking aprons will be reviewed monthly by the Maintenance Director or designee to ensure they are clean and in good repair.  
  
Raised flower beds and thresholds will be reviewed monthly as part of a routine safety audit by the Maintenance Director or designees to ensure no safety hazards are present.

**MONITORS**  
Beginning the week of 9/23/15, members of the IDT will complete weekly environmental rounds to identify safety hazards for 1 month then monthly for 2

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F 323	Continued From page 28  On 7/16/15 from 9:30 AM to 10:15 AM, during the environmental tour, the MA was shown the threshold and he said, "It's coming apart and needs to be replaced."  F 325 SS=G 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to identify and completely assess severe weight loss in a timely manner, and prevent further weight loss, for 1 out of 23 residents (Resident #4). The failure resulted in harm when Resident #4 experienced a severe weight loss of 7.9% in 31 days; the facility did not attempt to determine the causes for this severe weight loss for 15 days, by which time the resident had already lost an additional 2.5 lbs. Findings include:  Resident #4 was admitted 11/14/14 with multiple diagnoses, including dysphagia and dementia.	F 323	months. Findings will be investigated further by the Administrator or designee to allow for further re-education and performance improvement plans as indicated.  F 325 The Administrator or designee will review audit results as they are completed to identify the cause of the deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required.  Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Committee Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance.  <b>Date of Compliance</b> 9/23/15  F325 <b>RESIDENT SPECIFIC</b> Resident #4 discharged from facility on 8/10/2015 and no longer resides in this facility.  <b>OTHER RESIDENTS</b> Review of current residents with significant weight changes was completed on or before 7/27/15 by the Manager of Clinical Operations. Members of the nurse management team completed	

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F 325	<p>Continued From page 29</p> <p>The 6/20/15 Quarterly MDS Assessment coded the resident:</p> <ul style="list-style-type: none"> <li>*Had a BIMS of 2 (severe cognitive impairment);</li> <li>*Required extensive one-person assistance when eating;</li> <li>*Experienced significant weight loss over the previous 6 months;</li> <li>*Provided a mechanically altered diet;</li> <li>*Held food in the mouth/cheeks when eating; and,</li> <li>*Experienced coughing/choking during meals.</li> </ul> <p>The July 2015 ADL Care Plan documented the resident required extensive assistance with eating (initiated 11/20/14). The Nutrition Care Plan (initiated 11/21/14) documented the resident was at nutritional risk related to "poor intake-dysphagia, decreased cognition-decline..." and documented the interventions as:</p> <ul style="list-style-type: none"> <li>*Honor food preferences within meal plan [initiated 11/21/14];</li> <li>*Provide small portions [initiated 11/21/14];</li> <li>*Monitor for changes in nutritional status (change in intake, ability to feed self, unplanned weight loss/gain...) [initiated 11/21/14];</li> <li>*Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake [initiated 11/21/14];</li> <li>*Provide diet as ordered [initiated 11/21/14];</li> <li>*House supplement as ordered [initiated 11/21/14];</li> <li>*Encourage patient to come to dining room for meals [initiated 11/21/14];</li> <li>*Offer/encourage fluids of choice [initiated 1/13/15]; and</li> <li>*Weigh monthly and alert dietitian and physician to any significant loss or gain [initiated 3/31/15].</li> </ul> <p>The June 2015 Physician Recapitulation orders documented:</p>	F 325	<p>notifications and updated resident's plan of care following review on or before 9/23/15. Interdisciplinary Team completed a review of weight changes, interventions, and updated weight/nutrition care plan on or before 9/23/15.</p> <p><b>FACILITY SYSTEMS</b></p> <p>On or before 9/23/15 Re-education was provided to nursing staff by the Nurse Practice Educator or designee on the requirements of compliance under F325, and facility practices including, but not limited to, obtaining initial weight, re-weight, documentation of weight, determining root cause/etiology of weight change and completing notifications in a timely manner.</p> <p>On or before 9/23/15, facility's Registered Dietician was re-educated by the Manager of Clinical Operations related to review of residents with weight changes including intakes of meals and snacks, involvement of residents' support system and physician, and determining underlining etiology.</p> <p>Effective 9/1/15 facility's clinical morning meeting includes a review of weight changes as well as recommendations by therapy services to assist with weight management.</p> <p>On or before 9/23/15 weekly customer at risk meetings will be held to include IDT</p>	

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F 325	<p>Continued From page 30</p> <p>*Chart amount of meals taken, if 50% of meal not consumed offer substitution [started 11/14/14]; and,</p> <p>*Weigh every day shift every 1 month on the 1st day... [started 12/1/14];</p> <p>*Regular/liberalized diet, dysphagia puree texture, thin liquids [started 1/12/15];</p> <p>*House supplement with meals [started 6/16/15].</p> <p>The 4/22/15 Speech Therapy Discharge Summary documented, "Puree texture remains the safest and most efficient diet for this resident; however, she can tolerate dysphagia advanced items on special occasions (i.e. cake with activities) with supervision, setup, and ample time. Setup should include cutting items into small pieces and/or adding moisture to dry items; supervision should include watching for pocketing or inability to chew a bit after a while, then she should be encouraged to drink liquids and/or spit the item out to avoid choking hazard. Resident should be routinely encouraged to alternate liquids and solids with all po [oral] intake."</p> <p>The interventions documented in the speech therapy plan were not documented in the care plan. Refer to F280 for more details. Further, these recommendations were not clearly communicated with the care team; if the resident preferred solid food to pureed food, it could not be determined the resident would receive assistance per those recommendations. Refer to F309 for more details.</p> <p>The June Weights and Vitals Summary documented on 5/1/15 and 5/4/15 the resident was 126.5 lbs, and weighed 116.5 lbs on 6/1/15. On 6/15/15, the resident weighed 114 lbs.</p>	F 325	<p>review of individual resident weight concerns in order to determine the root cause related to weight change, and initiate documentation of findings.</p> <p><b>MONITORS</b> Beginning the week of 9/23/15, members of the nurse management team will complete weekly audits related to weight changes to assure re-weights occur following the identification of the weight change, timely notification of weight change, involvement of residents' support system and physician and root cause/etiology is identified for 1 month then monthly for 2 months.</p> <p>The Director of Nursing or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p>	

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F 325	<p>Continued From page 31</p> <p>The resident lost 10 lbs in 31 days, a severe weight loss of 7.9%, then 15 days later had lost another 2.5 lbs.</p> <p>The 6/16/15 Nutritional Assessment documented the resident had a 9.8% weight loss in one month, indicated "significant weight loss," and documented there was no previous weight loss trend. It summarized, "Pt [patient] has had sig [significant] weight loss of 9.8% over this last month, from 126.5lbs to 114 lbs with BMI at 19.6 normal weight. Pt is on puree diet and assisted with all meals in DR [dining room]..." This Nutritional Assessment went on to document unintended weight loss was "related to decreased intakes with decline/advanced age." It calculated caloric needs for the resident as 1,953 calories a day and indicated the resident's intake was not meeting this caloric need. Interventions for the "significant" weight loss included adding a house supplement to the breakfast meal, encouraging intakes of more than 50% (and offering a substitute if not), and offering snacks between meals.</p> <p>This assessment did not address why the resident lost 10 lbs in 1 month (changes in the resident's intake status, if there was an underlying medical cause of the weight loss, etc.). On 7/17/15 at 8:45 a.m., during interview with the Dietician, she stated monthly weights were taken the 1st through 3rd day of the month, then re-weights are taken the 4th and 5th. These weights were then reviewed by the Dietician for all residents each Thursday. According to this process, review of the "significant" weight loss should have been completed 6/11/16; however, the assessment was completed done until 5 days after this date.</p>	F 325	<p><b>Date of Compliance</b> 9/23/15</p>	
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F 325	<p>Continued From page 32</p> <p>On 6/18/15 a faxed notification documented the MD was notified of a weight loss of 23 lbs (16.8%) over 6 months and 14.5 lbs (11.3%) over 3 months. The physician's response was documented as, "okay."</p> <p>The June 2015 ADL record documented 8 instances the resident refused meals and 9 instances the resident ate 25% or less of a meal (90 meals offered in June 2015). It also documented the resident refused the bedtime snack 25 of 30 times it was offered. It could not be determined from the medical record why the resident refused meals or snacks, or if the resident was offered more food when she did not eat more than 50% of the meal, as physician ordered.</p> <p>On 7/17/15 at 8:45 a.m., the Dietician was interviewed about Resident #4's severe weight loss in June. She stated the decreased weight loss documented on 6/1/15 (116 lbs) was first reviewed on 6/16/15 (15 days after "significant" weight loss was identified). She confirmed interventions included increased house supplement three times a day, monitoring intakes, and continuing the current interventions (encouraging snacks between meals). When asked why the resident was refusing the HS snack, she stated she did not know. She stated additional calories were added to her diet, but confirmed this was not documented in the resident's medical record. She also stated it was not documented if the resident was offered more food when meal intake was less than 50%. She stated the resident "is expected to lose weight because of aging," however clinical documentation of this could not be determined.</p>	F 325		

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F 325	<p>Continued From page 33</p> <p>On 7/17/15 at 11:24 a.m., the Dietician stated the MD was notified once of the weight loss in June and his reponse was "okay." She stated "the family was notified but that is the extent of involvement from the MD and family."</p> <p>The resident was harmed when she experienced a 7.9% weight loss in 1 month, wasn't re-assessed following this event for 15 days, and lost another 2.5 lbs during this time period. In addition:</p> <ul style="list-style-type: none"> <li>* The assessment documented there was no previous weight loss trend, yet the assessment did not attempt to determine possible reasons (e.g. decreased meal intake, refusal of snacks, decreased physical function, underlying medical condition) for why the resident experienced a severe weight loss in one month;</li> <li>* Physician and family involvement in slowing or reversing the severe weight loss was minimal;</li> <li>* The etiology of the weight loss was documented as "aging/decline" without investigation or clinical documentation of this conclusion;</li> <li>* Physician notification did not occur until 17 days after the weight loss was discovered; and</li> <li>* The facility failed to assess or determine why the resident refused snacks or whether additional food was offered with consumption was measured at less than 50-percent.</li> </ul> <p>It could not be determined if the resident's meal intakes would have improved had solid foods, rather than pureed textured foods, were offered as this information was not communicated by Speech Therapy to the Care Team (refer to F309) and Speech Therapy recommendations for high-caloric interventions, and offering more food with decreased meal intake were not documented</p>	F 325		

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F 325  F 328 SS=D	<p>Continued From page 34 in the Care Plan (refer to F280).</p> <p>On 7/17/ at 6:30 p.m., the Administrator and DON were notified of this issue.</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility did not administer oxygen as ordered by the physician and did not develop a respiratory care plan for a resident who used BiPAP (Bi-level Positive Airway Pressure) and nebulizer treatments. This was true for 2 of 2 residents (#s 1 &amp; 22) and 1 Random Resident (#31) sampled for the care of oxygen and BiPAP services. This deficient practice created the potential for more than minimal harm should residents experience a drop in oxygen saturations or their respiratory condition worsened when respiratory care orders were not clarified, followed, or care planned. Findings included:</p>	F 325  F 328	<p><b>F328 RESIDENT SPECIFIC</b></p> <p>Resident #1 discharged on 7/30/15 and no longer resides at this facility.</p> <p>Resident #22 received a respiratory assessment by LN on 7/20/15 with finding documented in medical record with no abnormal finding identified.</p> <p>Resident #31 discharged on 7/14/15 and no longer resides at this facility</p> <p><b>OTHER RESIDENTS</b></p> <p>Review of current resident with O2, BI-PAP, and CPAP orders was conducted on or before 9/23/15 by nurse managers. Orders were clarified to reflect facility policy and the community standard of care. MD and families were notified as indicated through review of new and clarified orders. Orders for SPO2 monitoring were clarified for residents with oxygen orders to ensure therapeutic level is identified.</p> <p>On or before 9/23/15 members of the nurse management team reviewed current residents with oxygen orders to assure residents were on prescribed liter flow. Any identified concerns were corrected at time of review.</p>

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F 328 Continued From page 35

1. Resident #22 was admitted to the facility on 6/6/12, and readmitted on 6/1/15, with diagnoses of infantile cerebral palsy, dysphagia, epilepsy and adult failure to thrive.

The resident's July 2015 Medication Review Report (recapitulation) documented a 6/1/15 order for oxygen at 1 liter per minute via nasal cannula continuously every shift and for oxygen tubing to be changed weekly on Sunday. The order did not include monitoring for O2 (oxygen) saturations.

On 7/13/15 at 7:50 AM, Resident #22 was observed as he was assisted in his room by CNA #19. The resident was in his wheelchair by the sink and CNA #19 was cleaning the resident's glasses. It was observed that the portable oxygen tank had not been turned on and was set at "0." liters per minute (lpm) CNA #22 was shown the portable oxygen tank and stated that he could not turn the oxygen tank on because it was considered a medication.

On 7/13/15 at 7:55 PM, LN #6 was shown the portable oxygen tank and stated, "We need to turn the buddies on, we should be turning it on prior to the CNA taking him. He should have notified me."

Record review documented a care plan for the focus of complications related to the need for oxygen had not been developed prior to the week of survey, but was initiated on 7/14/15, the day after the oxygen concern was discovered. The 7/14/15 Oxygen Care Plan documented an intervention to monitor and report oxygen saturation levels via pulse oximetry as ordered and PRN; the Care Plan for oxygen did not

F 328

On or before 8/31/15 a review of current residents admitted in the last 30 days from time of review was conducted by Nurse Managers to ensure resident with orders for O2, Bi-PAP, and CPAP were in compliance with facility policy and procedures, and that the appropriate Care Plan was initiated.

**FACILITY SYSTEMS**  
On or before 9/23/15 O2, Bi-PAP, and CPAP requirements have been added to the Admission Record Review form by the Director of Nursing or designee to validate implementation of, and ensure that, orders are in compliance with Physician Orders and facility policy and that the care plan is initiated appropriately and timely.

Nursing staff were educated on oxygen administration and documentation, and the facility CPAP/BIPAP policy and procedure on or before 9/23/15 by members of the nurse management team to ensure understanding of the system changes as well as other requirements found under F328.

**MONITORS**  
Beginning the week of 9/23/15 members of the Nurse Management team will conduct an audit of residents with O2, Bi-PAP, and CPAP orders weekly for 4 weeks and then monthly x2 months to ensure O2 is administered per MD order, and CPAP and Bi-PAP orders are in compliance with facility policy and procedures.

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F 328	<p>Continued From page 36 include monitoring for O2 saturations.</p> <p>On 7/17/15 at 9:45 AM, the DON was made aware of the concern regarding oxygen for Resident #22.</p> <p>2. Resident #1 was admitted to the facility on 6/25/09, and readmitted on 6/25/15, with diagnoses including paraplegia, Hodgkin's Disease, malignant lymphomas and pneumonia.</p> <p>Record review of the facility's Bi-level Positive Airway Pressure (BiPAP/Continuous Positive Airway Pressure (CPAP) Policy and Procedure (P&amp;P), effective 1/1/04 and revised on 1/2/14, documented, "Orders must include pressure and hours of use and may include supplemental oxygen and mask size. For BiPAP, orders must also include Expiratory Positive Airway Pressure and Inspiratory Positive Airway Pressure, and may include mode of delivery and respiratory rate." Additionally, the P&amp;P directed staff how to clean the unit should be cleaned weekly, and instructed staff to document settings, mask size, date and time BiPAP/CPAP was initiated, supplemental oxygen (if applicable), tolerance (if applicable), tolerance of BiPAP/CPAP and mask, education of patient, staff, and family, patient education, skin irritation (if applicable) and notification of physician/mid-level provider (if applicable).</p> <p>The resident's July 2015 Medication Review Report documented the following orders: **6-25/15 - O2 2-4 L[liters per minute] via NC [nasal cannula] as needed for SOB [shortness of breath]. May titrate up to 4 lpm [liters per minute] via NC as needed for shortness of breath; *9-30-14 - Change oxygen tubing, water and</p>	F 328	<p>The Director of Nursing or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> <b>9/23/15</b></p>	

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F 328	<p>Continued From page 37</p> <p>clean filter weekly every night shift every Sun[day]; *6/25/15 - DuoNeb Solution 0.5-2.5 (3) MG/3 ML (Ipratropium-Albuterol) 3 ml inhale orally four times a day for pneumonia; and, *6/25/15 - BiPAP 12/8 with 2 L O2 two times a day for sleep apnea, initiated 6/25/15."</p> <p>On 7/1/15 at 2:04 AM, A PN (Progress Note) documented, "Encourage use of bi-pap at night, resident attempt use for several hours ending by 1:00 AM."</p> <p>On 7/2/15 at 2:09 AM, a PN documented, "Resident informed of risk and benefit of bi-pap use. Resident decline use after several attempts, stating mask did not feel right."</p> <p>A 7/9/15 Physician's Progress Note documented, "Continue BiPAP. Needs mask re-fitting by DME [Durable Medical Equipment] so that she can continue BiPAP use."</p> <p>A 7/9/15 Physician's Order documented, "Continue BiPAP, Ask DME to re-fit mask. Ask for the ResMED Amara Mask. Leak is making her take off mask early."</p> <p>A 7/9/15 Pharmacy Order documented, "BiPAP 18/12 with 2 L oxygen. Please ask DME to re-fit mask. Amaraview."</p> <p>On 7/11/15 at 5:18 AM, a PN documented, "Late charting from 7/10/15 8:00 PM - Resident had a visit from resident's BiPap provider. The BiPap provider came to reset BiPap and assess the fitting. The mask was not refitted at this time. The BiPap mask provider stated that the mask was dirty and cleaned it himself, and that the dirt could</p>	F 328		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/17/2015
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NAME OF PROVIDER OR SUPPLIER  APEX CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704
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F 328	<p>Continued From page 38</p> <p>be causing the mask to not adhere to the resident's face and could be a potential cause of leaking and taught this nurse proper way of putting it on the resident's face to ensure proper fitting. He stated that if the resident continues to report about leaking, they will come back to refit the mask. Resident reported this nurse about the mask not fitting very well and leaking on the upper corner during the night. Will communicate with day shift and the BiPap mask provider to refit it."</p> <p>On 7/11/15 at 5:26 AM, a PN documented, "Wore BiPap mask for first half of the night." On 7/12/15 at 1:10 AM, a PN documented, "Wore BiPap mask most of the night." On 7/12/15 at 5:45 AM, a PN documented, "Resident took off the BiPap early this morning, around 3:00 AM, and refused to put it back on for the rest of the shift." On 7/13/15 at 4:36 AM, a PN documented, "Wore BiPap mask for about two hours and refused to have it on for the rest of the night." On 7/16/15 at 3:49 AM, a PN documented, "LS [lung sounds] noted with wheezing cont[tinues] with neb[ulizer] tx [treatment] and bi-pap encouraged resident refused."  On 7/16/15 at 2:55 PM, when asked about the poor fit of the BiPAP mask related to it's cleanliness, UM #10 stated, "I did not have orders to clean it so it wasn't put on the TAR." When asked if it had ever been cleaned, UM #10 stated, "Not that we have documented." When shown the facility's P&amp;P for Bi-level Positive Airway Pressure, UM #10 stated they were not following all of the components listed in the P&amp;P. When asked if the physician's order should have been clarified per their P&amp;P</p>	F 328		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 328 Continued From page 39  
regarding Expiratory Positive Airway Pressure and Inspiratory Positive Airway Pressure, mode of delivery and respiratory rate, UM #10 stated, "Yes." When asked if the resident had a care plan for oxygen, BiPAP or respiratory concerns related to the resident's recent hospital admission for pneumonia, she stated, "No, I don't have one and she should have a care plan for her respiratory concerns."

On 7/17/15 at 9:25 AM, the DON was asked if the mask leak had been fixed. She stated SMS Services (the DME provider for the resident's mask) had told her he would come back with the equipment he needed. The DON stated she knew the resident had been having trouble and she had spoken with the provider on 7/16/15 after meeting with the resident, who said it was still leaking. The DON stated the resident told her the mask still leaked the night of 7/15/15, and that she wouldn't wear it all night due to the leaking mask.

On 7/17/15 at 6:30 PM, the Administrator and DON were made aware of the concerns regarding proper care and treatment for respiratory care.

3. Resident #31 was admitted to the facility on 3/26/15 with multiple diagnoses, including hypertension.

The resident's 4/21/15 faxed physician's order and July 2015 MAR documented oxygen was to be administered via nasal cannula at 1 liter per minute when oxygen saturations were less than 90%.

F 328

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

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 328 Continued From page 40  
The resident's July 2015 MAR documented the resident had been administered oxygen due to shortness of breath on 7/13/15.  
  
On 7/13/15 at 4:35 PM, six surveyors observed the resident propel her wheelchair from the 500 hallway to the main lobby. An oxygen canister was observed on the wheelchair with the nasal cannula in her nose. The resident appeared to be short of breath. The canister was observed to be on empty and the liter flow was set at 3 liters. LN #3 was alerted to the resident's needs and stated the resident appeared to be short of breath and that the oxygen canister "had a little bit in it but needed to be filled." LN #3 removed the oxygen and had it filled.  
  
On 7/17/15 at 11:45 AM, the DNS said oxygen canisters were to be checked between meals or prior to a resident with an oxygen canister leaving the facility. She stated she could not explain why the resident's canister was empty or why the liter flow was on 3 lpm rather than 1 lpm.  
  
On 7/17/15 at 6:30 PM, the Administrator, DNS and MCO were informed of the issues.

F 328

F 332 483.25(m)(1) FREE OF MEDICATION ERROR  
SS=D RATES OF 5% OR MORE

F 332

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:  
Based on observation, record review, and staff interview, it was determined the facility failed to

**F332**  
**RESIDENT SPECIFIC**  
Resident #26 discharged from the facility on 7/21/15 and no longer resides in this facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/17/2015
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--------------------	--	---------------	---	----------------------

F 332 Continued From page 41  
maintain a medication error rate of less than 5-percent. This was true for 3 of 36 medications (8.3%) affecting 3 of 12 residents (#s 26, 27, and 28) during medication pass observations. The failure created the potential for more than the minimal harm if residents received less than the optimum benefit from the prescribed medications. Findings include:

1. Resident #26's recapitulated physician's orders, dated 6/30/2015 documented, "Lactobacillus Capsule...2 capsules by mouth three times a day."

On 7/13/15 at 11:20 AM, LN #4 was observed preparing and administering one Lactobacilli capsule when two were ordered for resident #26.

Review of Resident #26's July 2015 MAR documented LN #4's initials under the date of 7/13/15 at 12:00 PM to reflect the resident was administrated 2 capsules of the ordered Lactobacillus medication.

2. Resident #27's Physician Orders dated 6/23/15 documented: "Synthroid (levothyroxine) tablet 100 mcg...Give 1 tablet by mouth one time a day for Hyperthyroidism."

Review of the resident's July 2015 MAR documented LN #5's initials on 7/14/15 at the scheduled time of 4:00 PM to indicate she had administered the Synthroid.

According to The Nursing 2015 Drug Handbook 35th edition p. 846, "Give drug at the same time each day on an empty stomach, preferable 1/2 to 1 hour before breakfast."

F 332 Resident #27 Synthroid was reviewed by practitioner and order for administration time changed on or before 9/23/15.

Resident #28 continues to receive medications through the PEG tube. Medications were reviewed by medical practitioner on or before 7/30/15 and forms of medications have been changed to crushable and or liquid forms.

**OTHER RESIDENTS**  
Medication administration competencies including how to properly administer medications through a PEG tube will be administered by the Nurse Practice Educator or designee on or before 9/23/15 to Licensed Nurses to identify deficient practice and the need for ongoing individual education.

**FACILITY SYSTEMS**  
A 100% MAR to cart completed by pharmacy nurse on or before 8/30/15. Medication administration competencies including how to properly administer medications through a PEG tube will be administered by the Nurse Practice Educator or designee on or before 9/23/15 to Licensed Nurses to identify deficient practice and the need for ongoing individual education.

On or before 9/23/15 the Nurse Practice Educator or designee will provide education to Licensed Nurses regarding the requirements for compliance with

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

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 332 Continued From page 42  
On 7/14/15 at 4:55 PM, LN #5 was observed during the administration of residents #27's Levothyroxine 100 mcg. The Levothyroxine was administered 5 minutes before the dinner meal was to be served.

Immediately after the observation, LN #5 was interviewed regarding the administration of the Synthroid medication in applesauce and having the resident immediately transported to the dining room for her 5:00 PM meal. The LN was asked if this was considered administration of a medication on an empty stomach. The LN acknowledged that it was not.

3. CMS letter 13-02-NH refers to administration of medications via feeding tube (including PEG [percutaneous endoscopic gastrostomy] tubes) and documented, "The facility, in consultation with the pharmacist, must provide procedures for the accurate administration of all medications. The procedures must reflect current standards of practice, including but not limited to...flushing the feeding tube before, between, and after drug administration... failure to flush before and in between each medication administration is considered a single medication error..."

Resident #28's Physician's Recapitulation Orders for July 2015 included an order "NPO: All meds to be given via peg tube only. Resident is strict NPO [nothing by mouth] every shift." Another Physician's order dated 7/15/15 documented, "Enteral feed: Flush tube with 10 ml of water before each medication every shift or 10 cc as ordered and Flush tube with 150 cc of water. Total volume... Check tube for proper placement prior to each feeding, flush or medication administration."

F 332 F332 including the steps of administering medications through a PEG tube, education regarding hand hygiene when administering medications, the proper way to handle pills when preparing medications for a resident, the proper way to waste narcotics per policy, to be aware of how a medication order reads (whether via PEG or oral and if crushable or not) including the 5 Rights of Medication Administration and how and when to communicate with the pharmacy and MD if a medication needs to be changed to a different form of administration. Also included in the education is the facility practice on what to do if the medication card does not match the order in the MAR but the dosage may be calculated from the current card by placing a "Directions Changed Refer to Chart" sticker on the card until pharmacy can deliver the proper dose.

**MONITORS**  
Beginning the week of 9/23/15 the Nurse Practice Educator or designee will complete repeat medication administration competencies including the items covered in the above mentioned education with Licensed Nurses 5 times a week x 2 weeks, 3 times a week x 2 weeks then twice a week x 2 months.

The Administrator or designee will review audit results as they are completed to

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 332	<p>Continued From page 43</p> <p>The facility's policy and procedures for Enteral Medication Administration, dated 1/1/4 with revision date of 1/2/14 stated: "Prepare each medication in individual medicine cups... Crush pills and dissolve in medicine cups with 10-20 ml tap water... If medication is listed as "Do Not Crush" notify physician/mid-level provider to obtain alternate order which may include liquid preparation of medication."</p> <p>On 7/17/15 at 8:45 AM, LN #2 crushed 11 ordered medications together for resident #28 and was about to administer the medications via the PEG tube when she was stopped by the surveyor. LN #2 was asked by the surveyor if she was going to give all 11 of the crushed medications. LN #2 stated, "Yes." The surveyor asked LN #2 to step out of room and the LN was asked if the Oxycontin ER was to be crushed. LN #2 stated, "Oxycontin ER was crushable". Surveyor asked LN #2 to look at the prescription label again. Prescription label read, "OxyCONTIN Reformulated 20 mg tablet ER. Give one tablet by mouth every 12 hours. SWALLOW WHOLE-DON'T CRUSH/CHEW. May cause drowsiness." LN #2 said she would call pharmacy right away but did not say she would call the physician. LN#2 took the medications with her to the nurses station and called the pharmacy.</p> <p>At 9:05 AM, after LN #2 had called the pharmacy, the LN crushed each medication separately excluding the Oxycontin ER, which she withheld until an order could be received to change to a medication suitable for a PEG. The surveyor asked LN #2 if she usually crushed the medications together. LN #2 stated, "Most of them are compatible. It depends on how many</p>	F 332	<p>identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p>	

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

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OMB NO. 0938-0391

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--------------------	--	---------------	---	----------------------

F 332	<p>Continued From page 44</p> <p>there are." At 9:15 AM, the LN entered resident #28's room with the medications and explained to resident #28 what she was going to do. LN #2 turned off the tube feeding and flushed the PEG with 30 ml of tap water. LN #2 then mixed 20-30 ml tap water with each of the crushed medications, administered each medication, and flushed 30 ml of tap water in between each medication administered.</p> <p>NOTE: The LN's intent was to simultaneously administer all crushed medications mixed together until she was stopped by the surveyor.</p> <p>On 7/17/15 at 6:30 PM, the Administrator and DON were informed of the issue.</p>	F 332		
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interview, and medical record review it was determined the facility failed to ensure a resident was free from significant medication errors. This was true for 1 of 12 residents (#28) observed during the medication pass. This deficient practice had the potential for more than minimal harm if the resident experienced confusion, disorientation, bradycardia, hypotension, cardiac arrest, sedation, respiratory failure, and/or coma due to an overdose. Findings include:  Resident #28 was admitted to the facility on</p>	F 333	<p><b>F333 RESIDENT SPECIFIC</b> Resident #28 continues to receive medications through the PEG tube. Medications were reviewed by medical practitioner on or before 7/30/15 and forms of medications have been changed to crushable and or liquid forms.</p> <p><b>OTHER RESIDENTS</b> Medication administration competencies including how to properly administer medications through a PEG tube will be administered by the Nurse Practice Educator or designee on or before 9/23/15 to Licensed Nurses to identify deficient practice and the need for ongoing individual education.</p> <p><b>FACILITY SYSTEMS</b> A 100% MAR to cart completed by pharmacy nurse on or before 8/30/15.</p>	

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 333	<p>Continued From page 43</p> <p>7/7/15 with multiple diagnoses, including cerebrovascular accident (CVA), hemiplegia, dysphagia, pneumonia, and a newly placed PEG tube.</p> <p>Resident #23's Physician's Recapitulation Orders for July 2015 documented, "NPO: All meds to be given via peg tube only. Resident is strict NPO [nothing by mouth] every shift," and "Oxycodone HCl Tablet 20 MG...every 12 hours for pain." An additional physician's order, dated 7/15/15, documented, "Flush tube with 10 ml of water before each medication every shift or 10 cc as ordered and Flush tube with 150 cc of water...Check tube for proper placement prior to each feeding, flush or medication administration."</p> <p>Resident #28's July 2015 MAR documented, "OxyCODONE HCl Tablet by mouth every 12 hours for Severe pain." In the same item area, the words "by mouth" had one line through it, and the handwritten documentation, "via PEG 7/16/15" and "Oxycontin ER [Extended Release]." Staff initials were documented from 7/7/15 through 7/16/15 at the scheduled times of 8:00 AM and 8:00 PM to indicate the Oxycontin ER or the Oxycodone had been administered.</p> <p>The facility's policy and procedures for Enteral Medication Administration, dated 1/1/4 with a revision date of 1/2/14, stated: "Prepare each medication in individual medicine cups. Crush pills and dissolve in medicine cups with 10-20 ml tap water. If medication is listed as "Do Not Crush" notify physician/mid-level provider to obtain alternate order which may include liquid preparation of medication."</p> <p>Black Box Warning issued from the FDA</p>	F 333	<p>Medication administration competencies including how to properly administer medications through a PEG tube will be administered by the Nurse Practice Educator or designee on or before 9/23/15 to Licensed Nurses to identify deficient practice and the need for ongoing individual education.</p> <p>On or before 9/23/15 the Nurse Practice Educator or designee will provide education regarding the requirements for compliance with F332 including the steps of administering medications through a PEG tube, education regarding hand hygiene when administering medications, the proper way to handle pills when preparing medications for a resident, the proper way to waste narcotics per policy, to be aware of how a medication order reads (whether via PEG or oral and if crushable or not) including the 5 Rights of Medication Administration and how and when to communicate with the pharmacy and MD if a medication needs to be changed to a different form of administration. Also included in the education is the facility practice on what to do if the medication card does not match the order in the MAR but the dosage may be calculated from the current card by placing a "Directions Changed Refer to Chart" sticker on the card until pharmacy can deliver the proper dose.</p> <p><b>MONITORS</b></p>	

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

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OMB NO. 0938-0391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	<p>Continued From page 46</p> <p>indicated, "Don't crush or dissolve controlled-release tablets...Patient must swallow whole...Chewing, crushing, snorting or injecting it can lead to overdose and death."</p> <p>On 7/17/15 at 8:45 AM, the surveyor observed LN #2 crush 11 ordered medications together for Resident #28 and was about to administer the mixed medications via the PEG tube when she was stopped by the surveyor. LN #2 was asked by the surveyor if she was going to administer all 11 of the crushed medications. LN #2 stated, "Yes." The surveyor asked LN #2 to step out of room and the LN was asked if the Oxycontin ER was to be crushed. LN #2 stated, "Oxycontin ER was crushable". The surveyor asked LN #2 to look at the prescription label again, which read, "OxyCONTIN Reformulated 20 mg tablet ER. Give one tablet by mouth every 12 hours. SWALLOW WHOLE-DON'T CRUSH/CHEW. May cause drowsiness." LN #2 said she would call the pharmacy immediately but did not say she would call the physician. LN#2 took the medications with her to the nurses station and called the pharmacy.</p> <p>At 9:05 AM, after LN #2 had called the pharmacy, the LN crushed each medication separately excluding the Oxycontin ER, which was withheld until an order to change to a medication suitable for a PEG was received. The surveyor asked LN #2 if she usually crushed the medications together. LN #2 stated, "Most of them are compatible. It depends on how many there are."</p> <p>On 7/17/15 at 6:30 PM, the Administrator and DON were informed of the issue.</p>	F 333	<p>Beginning the week of 9/23/15 the Nurse Practice Educator or designee will complete repeat medication administration competencies including the items covered in the above mentioned education with Licensed Nurses 5 times a week for 2 weeks, then 3 times a week for 2 weeks then twice weekly for 2 months.</p> <p>The Director of Nursing or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2105, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the plan of correction made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p> <p><b>F368</b> <b>RESIDENT SPECIFIC</b></p>	
F 368	483.35(f) FREQUENCY OF MEALS/SNACKS AT	F 368		

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

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  APEX CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
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F 368  
SS=D

Continued From page 47  
BEDTIME

Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.

The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

This REQUIREMENT is not met as evidenced by:  
Based on a complaint from the general public, resident group interview, and record review, it was determined the facility failed to consistently provide bedtime snacks for 1 of 6 sampled residents (#12). This deficient practice had the potential for harm if residents went hungry, or experienced adverse blood glucose fluctuations and/or altered nutritional status. Findings included:

The Idaho Department of Health and Welfare received a complaint from the general public in May 2015 alleging the facility did not consistently offer or provide bedtime snacks to residents.

Resident #12 was admitted to the facility on

F 368

Resident #12 discharged from the facility on 5/10/15 and no longer resides at this facility.

**OTHER RESIDENTS**  
The Manager of Clinical Operations completed a review of residents who resided in the facility on 7/27/15 to ensure HS snacks were offered to residents. As indicated through this review, education on the proper documentation of HS snacks was provided to nursing staff by Director of Nursing or designee on or before 7/31/15.

**FACILITY SYSTEMS**  
Beginning the week of 9/23/15 ADL records will be checked prior to and reported on the during morning clinical meeting to ensure that HS snacks are offered and documented. Additionally, residents will be interviewed during monthly dietary council to identify snack availability and options.

CNAs were re-educated to ensure that HS snacks acceptance or refusal is documented daily on the ADL sheet by the Director of Nursing or designee on or before 9/23/15.

**MONITORS**  
Beginning the week of 9/23/15, members of the nurse management team will review H5 snack documentation in resident's ADL records five times weekly for 4 weeks then weekly for 2 months to

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

PRINTED: 09/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  APEX CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704	
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F 368	<p>Continued From page 48</p> <p>5/4/15 with diagnoses of rehabilitation aftercare following joint replacement, anxiety, depression, and muscular wasting. The resident discharged from the facility on 5/9/15.</p> <p>A review of the ADL Record revealed the resident accepted a snack on 5/5/15 and 5/7/15; the record did not reflect the resident was offered a snack on 5/6, 5/8/ or 5/9.</p> <p>On 7/14/15 at 1:14 PM, a group of five residents stated without dissent that snacks were not offered to residents, but were available at the nurses station; the facility often ran out of bedtime snacks before each resident desiring a snack was able to choose one; and the selection of snacks available was severely limited.</p> <p>On 7/17/15 at 6:30 PM, the Administrator, Facility RD, and DON were informed of the issue.</p>	F 368	<p>assure resident were offered HS snacks nightly. Findings will be investigated further by to the RN Unit Manager or designee to allow for further re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2105, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the plan of correction made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p> <p><b>F411</b> <b>RESIDENT SPECIFIC</b> Resident #16 discharged on 3/8/2015 and no longer resides in this facility.</p> <p><b>OTHER RESIDENTS</b> A review of center grievances and resident Changes of Condition related to</p>
F 411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</p> <p>The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p>	F 411	

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F 411	<p>Continued From page 49</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to provide residents with dental services to replace lost dentures. This affected 1 of 1 (#16) sampled residents for dental services. This had the potential to cause harm if residents lost weight, experienced a sore mouth or infections, or were not able to chew food due to lack of dental services. Findings included:</p> <p>Resident #16 was admitted to the facility on 8/28/13 with diagnoses which included palliative care, pain, and muscular wasting and disuse atrophy.</p> <p>A 2/16/15 Grievance/Concern Form, filed by Resident #16's family member, documented the resident's dentures were missing. The investigation documented a date to be resolved by, which was blank. The resolution of the grievance was dated 3/17/15 and documented the resident was eligible through Medicaid to receive new dentures.</p> <p>Note: The date of the grievance resolution was after the resident discharged from the facility to a local hospital on 3/8/15.</p> <p>On 7/17/15 at 8:35 AM, the LSW stated she had spoken with a CNA who remembered seeing the dentures on the counter in a blue bowl in the resident's former room, but had not seen them since the resident changed rooms on 1/15/15. The LSW stated she left the resident's family member a phone message that the dentures were not found, but had not heard back from the</p>	F 411	<p>dental concerns during the last 30 days was completed on or before 9/23/15 by the Administrator or designee to ensure identified concerns were addressed within a timely manner.</p> <p><b>FACILITY SYSTEMS</b> On or before 9/23/15 the Administrator or designee completed education with LSW regarding meeting the requirements for compliance with F411 and the need to provide supporting documentation.</p> <p>On or before 8/31/15 additional resources for the provision of dental services for residents with limited financial resources have been identified.</p> <p><b>MONITORS</b> Beginning the week of 9/23/15, members of the IDT will conduct an audit of 5 current residents and compile the findings weekly for 4 weeks then monthly for 2 months, to ensure that routine or emergency dental services are attained. Findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 411	Continued From page 50 family. The LSW stated a family member told a CNA she wanted the dentures replaced, however the resident discharged to a local hospital on 3/8/15 and after that the family member did not return any of her phone calls. When asked if she had documentation regarding the missing dentures, the LSW provided a 3/9/15 Progress Note. However, she stated she did not have documentation regarding the missing dentures before that time.  On 7/17/15 at 9:45 AM, the DON stated that dentures are usually care planned in the ADL Care Plan, however Resident #16's Care Plan did not include denture information.  On 7/17/15 at 6:30 AM, the Administrator and DON were made aware of the concern.	F 411	performance improvement plans as indicated.  Beginning in October 2105, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.  Date of Compliance 9/23/15		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the	F 431	<b>F431 RESIDENT SPECIFIC</b> Resident #1 discharged from facility on 7/30/15 and no longer resides at this facility.  Resident #13 discharged from facility on 2/26/15 and no longer resides at this facility.  Resident # 25 discharged from facility on 8/17/15 and no longer resides at this facility.  Resident #28's order for extended release medication was clarified by RN unit manager or designee and clarified orders were received from Medical Practitioner on or before 9/23/15.		

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F 431	<p>Continued From page 51</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure medications were labeled in accordance with current physician orders, medications were available for administration, and controlled medications were properly disposed of by two Licensed Nurses. This was true for 6 of 36 medications observed during medication pass and created the potential for:</p> <ul style="list-style-type: none"> <li>* Residents #1, #25 and #28 to have uncontrolled pain;</li> <li>* Resident #29 to receive the wrong dose of Novolog;</li> <li>* Resident #8 to receive an oral, rather than enteral, dose of Bactofen;</li> <li>* Resident #13 to not receive his Zinc Sulfate; and,</li> <li>* The potential for narcotic drug diversion when two licensed nurses did not witness disposal of narcotic pain medications. Findings include:</li> </ul>	F 431	<p>Resident #29 order was sent to pharmacy for current dosing with new label provided on or before 9/23/15.</p> <p><b>OTHER RESIDENTS</b> Pharmacy's consulting RN completed a Medication Administration Record to Medication Cart Review on or before 8/30/15. Any identified conflicting information was corrected on or before 9/23/15 by members of the nurse management team.</p> <p>Medication administration competencies including how to properly administer medications through a PEG tube, 5 rights of medication administration, and narcotic destruction were administered on or before 9/23/15 by the Nurse Practice Educator or designee to licensed nurses to identify deficient practice or inappropriate administration techniques and the need for any further education.</p> <p><b>FACILITY SYSTEMS</b> Licensed nurses were educated on or before 9/23/15 by the Nurse Practice Educator or designee related to assuring medication labels correctly identify proper dosing and route. Medication administration competencies including how to properly administer medications through a PEG tube will be administered by the Nurse Practice Educator or designee to Licensed Nurses on or before 9/23/15.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431

Continued From page 52

1. On 7/17/15 at 8:40 AM, LN #2 was observed crushing 2 oxycodone pain medications and 1 Oxycontin ER pain med for Resident #28. The LN did not administer the crushed pain meds (refer to F 332 and F 333 for details about significant med errors).

On 7/17/15 at 8:47 AM, LN #2 said she would call the pharmacy about the crushed Oxycontin ER. The LN took the crushed meds to the nursing station then returned to the Med Cart in the hallway. When asked what she had done with the crushed pain meds, the LN stated, "I put them in the big sharps container, as she pointed toward the nursing station. When asked if another nurse observed the disposal of the meds, LN #2 stated, "[ADON 's name] walked by and I told her what I was doing." When asked if the ADON had observed the disposal of the meds, the LN stated, "No." LN #2 confirmed that she disposed of the pain meds without a second LN present.

The facility's policy and procedures for Management of Controlled Drugs, dated 8/1/05 with a revision date of 5/15/14, stated, "Destruction: Two licensed professionals are required to destroy and document destruction of controlled drugs."

Resident #28's Narcotic Sign Out Sheets Oxycodone 15 mg and Oxycontin ER 20 documented only LN #2's initials when the two pain meds were wasted on 7/17/15.

On 7/17/15 at 09:40 AM, the ADON was informed that a second LN had not witnessed the disposal of R #28's pain meds which the ADON acknowledged when she nodded her head yes.

F 431

**MONITORS**

Beginning of week 9/23/15, members of the nurse management team will complete weekly medication administration record to medication cart review for current residents for 4 weeks then monthly for 2 months. Findings will be corrected with re-education and performance improvement plans as indicated.

Beginning the week of 9/23/15 the Nurse practice Educator or designee will complete a medication administration competency including administration of medications through a PEG tube with Licensed Nurses 5 times a week for 2 weeks, 3 times a week for 2 weeks then twice a week for 2 months. Findings will be corrected with re-education and performance improvement plans as indicated.

The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.

Beginning in October 2105, the compiled results will be presented by the Director

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 53</p> <p>2. On 7/14/15 at 11:18 AM, LN #11 was observed as he administered one PRN Norco 10/325 mg tablet by mouth to Resident #1. The pharmacy label on the Norco medication documented, "...Give 2 tabs at each bedtime and give 1 to 2 tabs by mouth every 4 hours as needed for pain."</p> <p>On 7/15/15, a discrepancy was noted when the medication's pharmacy label was reconciled with the physician's order. Resident #1's July 2015 Physician's Recapitulation Order documented, "Norco...Give one tablet by mouth every 3 hours as needed for pain." The prn Norco order was dated 6/25/15.</p> <p>On 7/16/15 at 8:45 AM, the MCO provided the information and acknowledged the discrepancy between the resident's PRN Norco order and the medication's pharmacy label.</p> <p>On 7/17/15 at 6:30 PM, the Administrator and DON were notified of this issue.</p> <p>3. On 7/14/15 at 11:23 AM, LN #11 was observed as he administered a scheduled dose of Novolog insulin subcutaneously to Resident #29 before lunch. The pharmacy label on the Novolog documented, "Inject ...22 units twice daily (before lunch and dinner)." However, the LN administered 25 units of the insulin. The LN was immediately asked why he administered 25 units rather than 22 units and he responded that the order for the noon dose was changed to 25 units in April 2015. The LN showed the surveyor a 4/8/15 Physician Order/Response which included, "Novolog 25 units noon."</p> <p>On 7/16/15 at 8:20 AM, the DON was asked to</p>	F 431	<p>of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p>	

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F 431	<p>Continued From page 54</p> <p>provide a copy of Resident #29's Novolog insulin orders and July 2015 MAR. The Manager of Clinical Operations (MCO) was present when the request was made.</p> <p>On 7/16/15 at 8:45 AM, the MCO provided the requested information and acknowledged the discrepancy between the resident's Novolog insulin order and the medication's pharmacy label.</p> <p>4. On 7/16/15 at 11:40 AM, LN #11 was observed as he administered Baclofen 10 mg crushed and diluted in water via Resident #8's g-tube. The resident's medication pharmacy label read, "Baclofen 10 mg tablet. Give 1 tab by mouth three times daily." The pharmacy dispensed the Baclofen on 6/3/15.</p> <p>Resident #8's July 2015 Physician's Recapitulation Orders documented, "Baclofen Tablet, give 10 mg via G [Gastrostomy] -Tube..." There was a discrepancy in the route of administration. The Baclofen pharmacy label instructed "by mouth, however, the order instructed "via G-Tube."</p> <p>On 7/16/15 at 11:55 AM, LN #2 was asked if the resident received anything by mouth. The LN stated, "No" At that time, the DON joined the conversation. The DON said the resident had received meds via the G-tube since her admission in 2012. The DON acknowledged that the pharmacy label instructed the wrong route for the medication.</p> <p>5. Resident #13's February 2015 Physician's Recapitulation Report documented, "Zinc Sulfate 220 mg Give 1 mg by mouth in the morning for</p>	F 431		

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F 431	<p>Continued From page 55 supplement."</p> <p>The resident's February 2015 MAR documented an LN's initials with a circle on the days of 2/20/15 and 2/21/15. The facility's Summary of Investigation documented, "Director of Nursing completed the review... resident had not received the ordered Zinc Sulfate in the morning once daily on 2/20 and 2/21/15." Nurse's progress notes dated 2/21/15 at 2:56 PM, documented, "Zinc Sulfate not given this morning d/t (due to) not being available."</p> <p>On 7/16/15 at 3:20 PM, the DNS stated, the pharmacy did not provide over the counter [OTC] medications upon a resident's admission without a nurse first calling the pharmacy and requesting the medication. The DNS stated an LN called the pharmacy on 2/20/15, but the Zinc Sulfate was not delivered the next day, 2/21/15, and the medication was delivered to the facility on 2/22/15.</p> <p>6. Resident #25's July 2015 Physician's Recapitulation Orders documented "Hydromorphone HCl Tablet 8 mg by mouth every 3 hours for Pain."</p> <p>Resident #25's July 2015 MAR documented, "Hydromorphone HCl Tablet 8 mg Give 8 mg by mouth every 3 hours for Pain." The MAR documented the medication was administered on schedule from 7/10/15 through 7/17/15 with the exception of 6 entries on 7/11/15 at 11:00 AM and 2:00 PM, 7/13 at 11:00 PM, 7/14/15 at 11:00 PM, and 7/16/15 at 2:00 AM and 5:00 AM, which were left blank.</p> <p>On 7/16/2015 at 7:40 AM, LN #2 was observed</p>	F 431		

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F 431	<p>Continued From page 56</p> <p>telling the Resident #25 she was "going to try and call on the Dilaudid (hydromorphone) because the facility is out."LN #2 reported to Resident #25 she had called the on call pharmacy and they were "working on it."</p> <p>Resident #25's Progress Note, dated 7/16/2015 at 11:18 AM documented, "Late Entry: NP [Nurse Practitioner] was notified q [every] am [morning] r/t [related to] resident not receiving scheduled Dilaudid and NP then contacted PX [Pharmacy]. Who then delivered more pain meds at around 1300 [1:00 PM]."</p> <p>Resident 25's Progress Note, dated 7/16/2015 at 12:00 PM, documented a late entry: "As reported by night shift nurse, resident missed 2 doses of Dilaudid. Night nurse stated she called the pharmacy and the doctor. Per report pharmacy stated 'if you did not hear back from me tonight they are on there [sic] way.' Night shift nurse called pharmacy two more times through out [sic] the night. In the AM, this LN [LN #2] called pharmacy and they stated they would send some by 9 am. Pain assessment was completed ... Resident received other regular scheduled pain meds during this time."</p> <p>The facility's policy and procedures for Providing Pharmacy Services, dated 8/1/02 with a revision date of 3/1/11, documented, "When medication is needed prior to the next scheduled delivery and is not contained in the interim/stat/emergency drug supply, the pharmacist arranges for both the dispensing and delivery of medication to the Center ...contract."</p> <p>On 7/17/2015 at 10:00 AM, UM #10 and the ADON were asked why the facility did not have</p>	F 431		
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F 441	<p>Continued From page 58</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented for 2 of 24 sample residents (#s 7 and 22), and had the potential to impact any resident receiving care from LN # 17.. The failures placed the residents at risk for infection from cross contamination when Resident #7 and #22's indwelling urinary catheter tubing was in contact with the floor and staff did not perform hand hygiene after handling the tubing. Findings included:</p> <p>1. On 7/17/15 at 9:15 AM, Resident #7's Foley catheter tubing was observed dragging on the floor in the hallway while the resident self-propelled in his wheelchair.</p> <p>The surveyor immediately informed the DON of the infection control issue and the DON stated, " I just fixed that. " Then, with her bare hands, the DON placed the catheter tubing into a metal basket on the resident's wheelchair. The DON then went into her office and touched the door knob and the computer keyboard. When asked if she was going to wash her hands, the DON stated, "Let me go do that."</p> <p>2. On 7/15/15 at 2:00 PM, Resident #22 was</p>	F 441	<p>time of the competency on when one should wash their hands was completed with staff by the Nurse Practice Educator or designee.</p> <p><b>FACILITY SYSTEMS</b> Hand hygiene competencies with an in depth education done at that time of when one should wash their hands will be completed with staff by the Nurse Practice Educator or designee on or before 9/23/15.</p> <p>Education regarding the requirements of compliance with F441 including observation of catheter tubing on the floor, and how to address this issue was completed with staff by the Nurse Practice Educator on or before 9/23/15. Residents that use indwelling catheters will be offered the use of a leg bag to decrease risk of the catheter tubing touching floor.</p> <p><b>MONITORS</b> Beginning the week of 9/23/15 the Nurse Practice Educator or designee will complete repeat hand hygiene competencies with 3 staff daily x 2 weeks, then 5 competencies a week x 2 weeks, then 2 competencies a week x 2 months to ensure proper technique of hand hygiene as well as ensuring hand hygiene takes place in the appropriate circumstances.</p>	

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

PRINTED: 09/24/2015  
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OMB NO. 0938-0391

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F 441	<p>Continued From page 59</p> <p>observed being propelled in a wheelchair to the common area with his Foley catheter tubing dragging on the floor.</p> <p>On 7/15/15 at 3:05 PM, when shown the dragging Foley catheter tubing, LN #18 stated, "It's touching the floor. It shouldn't be touching anything." LN #18 then placed the tubing into a basket under the resident's wheelchair without performing any hand hygiene either before or after handling the tubing. LN #18 then walked to the nursing station and touched the side rail by the medication room. After a brief discussion with a surveyor, LN #18 then proceeded to the Unit Manager's Office, where she was asked if she was going to wash her hands. LN #18 stated "I should have washed my hands. Yes, I got distracted." The LN then went to the charting room and washed her hands.</p> <p>On 7/15/15 at 3:20 PM, Unit Manager (UM) #10 was notified of the catheter tubing and infection control concerns, to which she stated, "She [LN #18] should have washed her hands."</p> <p>3. On 7/15/15 at 8:00 AM, LN #17 was observed as she measured the blood glucose (BG) of Resident #28 and then left the room without performing hand hygiene. LN #17 returned to the medication cart, opened the drawer, retrieved cleaning wipes, and cleaned the glucometer. LN #17 then returned the wipes, closed the drawer and proceeded to the next room where she washed her hands.</p> <p>Immediately after the observation, LN #17 was asked what she would do if she found another resident on the floor in the hallway as she left Resident #17's room. The LN stated, "I would</p>	F 441	<p>Beginning the week of 9/23/15 the Nurse Practice Educator or designee will complete observation audits of proper hand hygiene and of catheter tubing touching the ground 4 times a week x 2 weeks, then twice a week x 2 weeks, then weekly x 2 months to ensure there is a decreased risk for spread of infection through the catheter tubing dragging on the ground.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> <b>9/23/15</b></p>	



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F 490	Continued From page 61  B. Refer to F252, F253, and F254- The facility failed to ensure a clean, comfortable, and homelike environment.  C. Refer to F325- The facility failed to identify and completely assess significant weight loss in a timely manner, and prevent further weight loss.  D. Refer to F328-The facility failed to ensure portable oxygen tanks contained oxygen and/or were turned on to meet residents' therapy requirements.  F 514 SS=E 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain complete and accurate clinical records for each resident in the facility. This was true for 4 of 23 (#s 6-8 & 17) sampled residents with incomplete	F 490	The Center Performance Improvement (PI) Committee which includes administrator, DON and other management team members will bring key clinical process metrics, audit results, resident council reports and other information warranting the Committee's discussion/actions to the monthly PI meeting. The Pharmacy consultant and medical director will also be in attendance at least quarterly.  F 514 <b>MONITORS</b> During the week of 9/23/15, the administrator will chair the performance improvement committee meeting and review resources brought to meeting by committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results and metric trends are acted upon.  Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The PI meeting will continue to occur monthly with regional support available and as needed.  Date of Compliance 9/23/15  F514 <b>RESIDENT SPECIFIC</b>

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F 514	<p>Continued From page 62</p> <p>documentation as evidenced by:</p> <ul style="list-style-type: none"> <li>*Recapitulation orders and MARs directed staff to administer medications by mouth for a resident capable of receiving medications only through a percutaneous endoscopic gastrostomy (PEG) tube;</li> <li>*Hospital records for a resident were found in another resident's medical record;</li> <li>*Tubigrip and geri-sleeve orders were not discontinued when they were no longer in use;</li> <li>*Recapitulation orders documented a resident was to receive counseling after it had been discontinued; and,</li> <li>*There were no consultation notes in the chart after a urological examination. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings included:</li> </ul> <p>1. Resident #8 was readmitted to the facility on 8/31/12 with multiple diagnoses, including hemiplegia.</p> <p>The resident's July 2015 Medication Review Report (Recapitulation orders) documented on 6/26/15, "Tylenol tablet...Give 650 mg by mouth as needed for pain..."</p> <p>The resident's June and July 2015 MAR documented, "Tylenol tablet...Give 650 mg by mouth as needed for pain..." The MARs were blank, indicating the resident dis not receive the medication.</p> <p>On 7/17/15 at 11:45 AM,when asked if the resident received any medications by mouth, the DNS said the resident did not. When shown the</p>	F 514	<p>Resident #6's urology progress notes were received from the urologist on 7/21/2015 by the Health Information Director and placed in the medical record.</p> <p>Resident #7's Treatment Administration Record were reviewed and updated to reflect the current patient orders, which do not include geri-sleeves or tubi-grips. Additionally, Resident #7's Medication Administration Record was reviewed and updated to reflect the current patient orders for route of administration for medications on or before 9/15/15 by RN unit manager or designee.</p> <p>Resident #8's Medication Administration Record was reviewed and updated to reflect the current patient orders for route of administration of medications on or before 9/15/15 by RN unit manager or designee.</p> <p>Resident #17 discharged on 5/14/2015 and no longer resides in this facility.</p> <p>Resident #7's emergency department record was removed from resident #17's medical record and placed in #7's medical record by the HIM on or before 8/31/15</p> <p><b>OTHER RESIDENTS</b></p> <p>Members of the clinical interdisciplinary team completed an audit of residents who have discharged in the last 30 days to assure their discharge record contained only their medical information on or</p>	

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F 514	<p>Continued From page 63</p> <p>Medication Review Report and the MARs the DNS stated, "I'm not sure why that's there," and noted the order should have been clarified.</p> <p>2. Resident #17 was admitted to the facility on 3/18/15 with multiple diagnoses, including osteoarthritis.</p> <p>On 7/15/15 at 3:05 PM, Resident #17's closed medical record was reviewed. A local hospital emergency department record dated 3/4/15 for Resident #7 was found in Resident #17's closed medical record.</p> <p>On 7/16/15 at 9:15 AM, the Health Information Manager was shown the medical records. She said Resident #7's emergency department record must have been misfiled in Resident #17's chart.</p> <p>3. Resident #6 was admitted to the facility on 5/13/15 with multiple diagnoses, including cystitis, bacteremia with sepsis, bladder neck obstruction, and GERD (Gastroesophageal Reflux Disease).</p> <p>The resident's 5/20/15 admission MDS assessment documented the resident had an indwelling catheter.</p> <p>Resident #6's Care Plan, last reviewed on 6/11/15, documented, "Requires indwelling catheter for urinary retention."</p> <p>On 7/14/15, Resident #6 stated he would have surgery on 7/27/15 "for my bladder... so I won't have to wear this tube [pointing to catheter] the rest of my life."</p>	F 514	<p>before 8/31/15. Members of the nurse management team completed a review of residents currently reside in the facility's recap orders on or before 9/1/15 and identified concerns were corrected or clarified by members of the nurse management team at time of review.</p> <p><b>FACILITY SYSTEMS</b></p> <p>Review of current residents was conducted by IDT on or before 9/23/15 to ensure that physician orders are updated and physician progress notes are received in a timely manner. Members of the Nurse Management team will access the Idaho Health Data Exchange for the purpose of obtaining physician progress notes and other clinical data in a timely manner.</p> <p>Clinical and Medical Records Staff were educated by the Nurse Practice Educator or designee on or before 9/23/15 on ensuring documentation is placed or recorded in the correct residents' chart, the accuracy of documentation and physician notification for resident refusals and other requirements for compliance with the guidance found under F514.</p> <p><b>MONITORS</b></p> <p>Beginning the week of 9/23/15, members of the IDT will conduct an audit of 5 current residents and compile the findings weekly for 4 weeks then monthly for 2 months, to ensure that Treatment Administration Records and Medication</p>	

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F 514	<p>Continued From page 64</p> <p>Medical records including Progress Notes, Physician's Progress Notes, and Consultant's Notes contained no information regarding an upcoming surgery.</p> <p>In addition, a 6/30/15 Social Service PN documented, "Resident expressing an increase in anxiety over dr (physician) appointment this afternoon with the urologist." The only other references in the resident's medical record to the urology appointment were two Social Service PNs on 6/16/15 and 6/18/15 that documented a referral was faxed to a urologist. The medical record did not document the appointment date/time nor why the resident was consulting with the urologist. The medical record also did not contain a Consultation Note from the 6/30/15 urology appointment.</p> <p>The resident's Unit Manger (UM) was not able to find a copy of the consultant's report and did not know the nature of the procedure, but indicated she was aware of the 7/27/15 surgery from a physician's note ordering NPO status for the night before surgery.</p> <p>4. Resident #7 was admitted to the facility on 12/24/14 with diagnoses of rehabilitation and encephalopathy.</p> <p>The resident's July 2015 Medication Review Report documented the following orders: *12/24/15 - Tamsulosin HCl Capsule 0.4 MG, 0.4 mg via J-Tube at bedtime for urinary retention; *12/24/15 - Thiamine HCl Tablet 100 MG, 100 mg via J-Tube one time a day for Supplement; *12/24/15 - Folic Acid Tablet 1 MG, 1 tablet via</p>	F 514	<p>Administration Records align with current patient orders. Additionally, members of the IDT will conduct an audit of charts of 8 current residents and compile the findings weekly for 4 weeks, then monthly for 2 months to ensure that physician progress notes are received in a timely manner and for accuracy of record filing. Findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>The Administrator or designee will review audit results as they are completed to identify the cause of any deficient practice and to ascertain trends in staff performance and to continue to monitor root cause improvement, or the need for process changes as required. Any findings will be corrected with re-education and performance improvement plans as indicated.</p> <p>Beginning in October 2015, the compiled results will be presented by the Director of Nursing during the QAPI Clinical Excellence Meeting monthly for a minimum of 3 months or longer to ensure sustained compliance, with revision of the performance improvement plan made as indicated.</p> <p><b>Date of Compliance</b> 9/23/15</p>	

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F 514	<p>Continued From page 65</p> <p>J-Tube one time a day for depression; *1/6/15 - Effexor XR Capsule Extended Release 24 Hour 150 MG [Venlafaxine HCl ER], 1 capsule via PEG-Tube one time a day for depression; *2/4/15 - Geri-sleeves ON in AM and OFF at Bedtime, every day and night shift for protection; *2/6/15 - Tubigrip's to bilateral lower extremities, on in AM, off at HS [hour of sleep] for skin integrity two times a day; *1/13/15 - [Outside Provider] may provide psychological services; and, *3/19/15 - Send to [hospital] for removal of peg tube.</p> <p>At no time during the survey week of 7/13/15 through 7/17/15 was the resident observed wearing geri-sleeves or tubi-grips on his arms or legs.</p> <p>On 7/15/15 at 7:30 AM, Resident #7 stated he hadn't worn tubi-grip's on his arms or legs for two months because it made him itch.</p> <p>The resident's June and July 2015 TAR documented the resident wore Geri-sleeves daily.</p> <p>On 7/15/15 at 3:25 PM, UM #10 stated the resident's Peg-Tube had been discontinued on 3/20/15 and that medications were now given by mouth. UM #10 was shown the geri-sleeve and tubi-grip orders with the June and July 2015 TAR and stated she had discussed discontinuing the order for geri-sleeves or tubi-grips with nurses since the resident didn't like to wear them, and those orders needed to be discontinued. When asked about the documentation on the TAR indicating the resident wore the geri-sleeves and tubigrips, UM #10 stated, "I can't attest to what the nurses saw, I haven't seen him wearing them.</p>	F 514		



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F 520 Continued From page 67  
the facility's compliance history, Resident Group interview, and staff interview, it was determined the facility's quality assessment and assurance (QAA) committee failed to take actions that identified and resolved systemic problems for 5 of 24 sampled residents (#s 1, 4, 8, 9, & 22), and 2 random residents (#s 30 & 31), with the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient direction and control necessary to ensure residents' quality of life and quality of care needs were met. Findings included:

The QAA committee failed to provide sufficient monitoring and oversight, and the ability to sustain regulatory compliance, as evidenced by the following citations for the current 7/17/15 annual recertification survey.

A. Refer to F241- The facility's QAA committee failed to ensure residents were treated with dignity and respect when an LN encouraged a resident to soil his/her briefs instead of taking the resident to the bathroom and posted a sign on a resident's wall disclosing private health information.

B. Refer to F252, F253 and F254- The facility's QAA committee failed to ensure a clean, comfortable, and homelike environment.

C. Refer to F328-The facility's QAA committee failed to provide for residents oxygen needs when a resident's oxygen canisters were not turned on or were found to be empty.

In addition, the QAA committee failed to provide sufficient monitoring and oversight, and the ability to sustain regulatory compliance in relation to a

F 520 The Center Performance Improvement (PI) Committee which includes administrator, DON and other management team members will bring key clinical process metrics, audit results, resident council reports and other information warranting the Committee's discussion/actions to the monthly PI meeting. The Pharmacy consultant and medical director will also be in attendance at least quarterly.

**MONITORS**  
During the week of 9/23/15, the administrator will chair the performance improvement committee meeting and review resources brought to meeting by committee members along with the compliance audits from this survey and resident council meeting minutes to ensure recommendations, audit results and metric trends are acted upon.

Results of recommendations and audits will be discussed by team members to include but not limited to cause identification with systematic reviews for necessary changes. The PI meeting will occur monthly with regional support available and as needed.

**Date of Compliance**  
9/23/15

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F 520 Continued From page 68  
previous citation at F325 during the 4/11/14 annual recertification survey. The facility was re-cited at F325 for the current 7/17/15 annual recertification survey.

F 520



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
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October 7, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Apex Center. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint or Entity-Report Incident #ID00006989**

**ALLEGATION #1:**

The complainant stated the dinner meals were not palatable and cold and the coffee was always cold.

**FINDINGS #1:**

The complaint was investigated in conjunction with the facility's Federal Recertification and State Licensure survey from July 13 to July 17, 2015.

Several staff were observed during the provision of cares and medication administrations for multiple residents. Interactions between staff members and residents were observed in dining rooms and in residents' rooms during meal times. Food temperature taking was observed and meal service food trays were tested by survey team members.

Joseph Rudd, Administrator  
October 7, 2015  
Page 2 of 3

The following records and documents were reviewed:

The identified resident's medical record;  
The medical records of twenty-three other residents related to Quality of Care concerns;  
The facility's Grievance files from January to July 2015;  
Resident Council meeting minutes from July 2014 to June 2015;  
The facility's Incident and Accident reports from August 2014 to July 2015;  
The facility's Allegation of Abuse reports from June 2014 to July 2015; and,  
Food temperature records.

The following interviews were completed:

Four residents and two family members regarding quality of life and quality of care;  
Two family members regarding quality of life and quality of care;  
Six residents in a Resident Group Interview regarding quality of life and quality of care;  
The Food Services Supervisor;  
The Registered Dietitian (RD);  
Several direct care staff, including licensed nurses and Certified Nursing Assistants; and,  
The Director of Nursing Services (DNS).

Test tray observations were determined to be palatable and at proper temperatures for both food and coffee. Residents and family members did not voice a concern regarding the food or coffee. Staff members interviewed said food is palatable and served at the proper temperature.

Based on test tray observations, record review and resident, family and staff interviews. It was determined the allegation could not be substantiated.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Snacks were rarely passed out in the evenings.

FINDINGS #2:

Based on record review and resident and staff interview, the allegation was substantiated and cited at F368.

CONCLUSION: Substantiated. Federal deficiencies related to the allegation are cited.

Joseph Rudd, Administrator  
October 7, 2015  
Page 3 of 3

**ALLEGATION #3:**

The identified resident did not receive adequate pain medication and received it late on several occasions.

**FINDINGS #3:**

The identified resident's medical record and 23 other residents records were reviewed. Medication pass was observed. Several residents and family members were interviewed and they said late medications were not a concern. Several nurses and the Director of Nursing was interviewed and they said medications were given as ordered and in a timely manner.

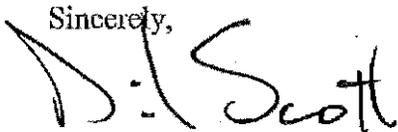
Based on observations, record review and resident, family and staff interviews, it was determined the allegation could not be substantiated.

**CONCLUSION:** Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, Supervisor  
Long Term Care

DS/pmt



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T. – Chief  
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October 7, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Apex Center. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint or Entity-Report Incident #ID00007107**

**ALLEGATION #1:**

The complainant stated an identified resident had minimal involvement from therapy, which resulted in the resident being bed- and wheelchair bound. Also, there were inconsistent therapeutic goals for physical and occupational therapy.

**FINDINGS #1:**

The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on July 13 to July 17, 2015.

\*\*\*The following observations were completed:

Medical equipment, including mechanical lifts and walkers, were observed throughout the survey, and Medication Pass was observed.

Joseph Rudd, Administrator

October 7, 2015

Page 2 of 7

The following documents were reviewed:

The medical record of the identified resident;

23 other residents' records were reviewed for Quality of Care concerns;

The facility's Grievance file from January to July 2015;

Resident Council minutes from July 2014 to June 2015;

The facility's Incident and Accident reports from August 2014 to July 2015; and,

The facility's Allegation of Abuse reports from June 2014 to July 2015.

The following interviews were completed:

Four residents were interviewed regarding Quality of Care concerns;

Two residents' family members were interviewed regarding Quality of Care concerns;

Six residents in the Resident Group were interviewed regarding Quality of Care concerns;

Two CNAs were interviewed regarding the accessibility of mechanical lifts in the facility;

The Director of Nursing and the Administrator were interviewed regarding various Quality of

Care concerns; and, the Director of Rehabilitation, a Physical Therapist, an Occupational

Therapist, and a Physical Therapist Assistant were interviewed regarding therapy concerns.\*\*\*

Five other resident's medical records were reviewed for therapy needs and therapeutic goals and no concerns were found, four residents and two residents' family members were interviewed and no therapy concerns were noted. Six residents in the Resident Group interview did not express concerns with therapy.

The identified resident's medical record was reviewed for therapy concerns. Physical and occupational progress notes documented the resident received therapy as ordered and specific goals were identified.

The Director of Rehabilitation said the resident received appropriate therapy for his/her condition and she discussed goals to the resident and family. A Physical Therapist, an Occupational Therapist and a Physical Therapist Assistant were interviewed and they all said they had worked with the identified resident, provided appropriate therapy for the resident and discussed the goals listed in the therapy plan of care with the resident.

Based on the record review, resident, resident's family and staff interviews it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated mechanical lifts were not readily available for staff to use with residents and staff had built a platform walker from parts taken from other residents medical equipment.

FINDINGS #2:

Medical equipment, including mechanical lifts and walkers, were observed throughout the facility during the survey.

Two CNAs were interviewed regarding mechanical availability and they said they have enough equipment for the residents needs and equipment is located throughout the facility.

The Director of Rehabilitation said mechanical and sit-to-stand lifts are not normally used for therapy but are a nursing tool- in a particular case a sit to stand during therapy sessions is used per resident request.

An Occupational Therapist said therapy uses a standing frame device, which is similar to a sit-to-stand, but residents refuse to use it.

A Physical Therapist said the sit-to-stand is only used during therapy evaluations, however she uses it for a resident to accommodate their wishes.

A Physical Therapist said there was one day when the battery stopped working on a sit-to-stand, but the battery was replaced that same day.

An Occupational Therapist and Physical Therapy Assistant said the platform walker is an adaptive device which is resident specific, so the facility has different parts for different resident's needs and it takes about five minutes to put on and take off the pieces. They said the parts are not taken from other resident's medical equipment.

Based on observation, the record review and staff interview it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an identified resident did not receive a pain medication prior to a therapy session. The resident could not participate in therapy due to the missed medication and staff marked the medication as a refusal.

**FINDINGS #3:**

The identified resident's medical record was reviewed for pain medications. Six other residents records were reviewed for pain medications.

Four residents were interviewed regarding Quality of Care concerns and pain medication was not an issue. Two residents family members were interviewed regarding Quality of Care concerns and pain medication was not an issue. Six resident's in the Resident Group were interviewed regarding Quality of Care concerns and they said they received their pain medications in a timely manner and prior to therapy.

Two CNAs were interviewed regarding the accessibility of mechanical lifts in the facility, and, a Physical Therapist, an Occupational Therapist, and a Physical Therapist Assistant were interviewed regarding pain medications prior to therapy and they said residents were medicated prior to the start of therapy.

Based on the record review, and Resident Group, resident, resident family and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #4:**

The resident developed a pressure sore, which deteriorated due to lack of preventative care and treatment.

**FINDINGS #4:**

Several residents and the identified resident's skin treatments and interventions were observed.

Several residents and the identified resident's treatment and prevention orders were reviewed.

Nursing staff and the Director of Nursing were interviewed regarding skin treatments and preventative care.

Based on observation, record review and staff interview it was determined the allegation could not be substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The Facility documented the resident was refusing medications when the resident was having emesis and not able to tolerate the medications and some foods.

**FINDINGS #5:**

Several residents and the identified resident's medical records were reviewed.

Based on record review it was determined the allegation could not be substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #6:**

The resident's physician's order for Prilosec was not implemented in a timely manner.

**FINDINGS #6:**

Based on record review, it was determined this allegation could not be substantiated for the identified resident, but was found for another resident and was cited at F431.

**CONCLUSION:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #7:**

The resident experienced a fall due to staff error, but the fall was documented as the resident's inability to participate in a transfer.

**FINDINGS #7:**

Based on record review, it was determined this allegation could not be substantiated for the identified resident, but a fall for another resident was cited at F323.

**CONCLUSION:**

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #8:

A Urinary Tract Infection (UTI ) and cellulitis were not recognized and treated, nor was pancreatitis, until family members insisted the resident be taken to the Emergency Room (ER) for evaluation.

FINDINGS #8:

Several residents were reviewed for Quality of Care concerns.  
The identified resident's UTI, cellulitis and pancreatitis treatment orders were reviewed.

Nursing staff and the Director of Nursing were interviewed regarding treatment of infections.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

The issues addressed by the allegation were brought to the attention of the facility leadership, particularly the DNS, but they have not been resolved.

FINDINGS #9:

The facility grievance file was reviewed and, grievances for the identified resident were reviewed.

Interviews with ten residents and two family members revealed they did not have a concern with management staff addressing their concerns. Management staff and the Director of Nursing were interviewed regarding resident and family concerns.

Based on record review, resident, family and staff interviews it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

Joseph Rudd, Administrator

October 7, 2015

Page 7 of 7

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "S".

DAVID SCOTT, RN, Supervisor  
Long Term Care

DS/pmt



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October 7, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Apex Center. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint or Entity-Report Incident #ID00006897**

**ALLEGATION #1.**

An identified resident was offered a meal upon admission. The resident requested first to use the bathroom. The resident was provided a urinal, but needed to have a bowel movement. The resident was taken to the bathroom, but not provided assistance to get out of, or back into the wheelchair. By the time the resident returned, the meal was cold.

**FINDINGS #1:**

The complaint was investigated in conjunction with the facility's Federal Recertification and State Licensure survey from July 13 to July 17, 2015.

Several staff were observed during the provision of cares and medication administrations for multiple residents. Interactions between staff members and residents were observed in dining rooms and in residents' rooms during meal times. Temping of foods was observed and meal service food trays were tested by survey team members.

Joseph Rudd, Administrator

October 7, 2015

Page 2 of 9

The following records and documents were reviewed:

The identified resident's medical record;  
The medical records of twenty-three other residents related to Quality of Care concerns;  
The facility's Grievance files from January to July 2015;  
Resident Council meeting minutes from July 2014 to June 2015;  
The facility's Incident and Accident reports from August 2014 to July 2015;  
The facility's Allegation of Abuse reports from June 2014 to July 2015; and,  
Food temperature records.

The following interviews were completed:

Four residents and two family members regarding quality of life and quality of care;  
Six residents in a Resident Group Interview regarding quality of life and quality of care;  
The Food Services Supervisor;  
The Registered Dietitian (RD);  
Several direct care staff, including licensed nurses and Certified Nursing Assistants; and,  
The Director of Nursing Services (DNS).

Based on observations of staff during the provision of care to multiple residents and resident and staff interviews, lack of staff assistance with toileting and/or cold food was not identified as an issue. Additionally, residents in the group interview said that cold food, which had been an issue previously, was better.

Per review of medical records for multiple residents, including the identified resident, lack of toileting assistance and cold food temperature was not identified. In addition, per the food temperature records and food test trays, cold food temperature was not identified as an issue.

Based on observations, records reviewed and interviews, it was determined the allegation could not be substantiated.

#### CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant questioned whether the RD was qualified.

#### FINDINGS #2:

Based on review of the identified resident's medical record, including diet orders, and the same for several other residents, as well as observations and multiple interviews, no irregularities were identified.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility agreed to provide a daily milkshake, however, the resident did not consistently receive this throughout his/her stay.

FINDINGS #3:

Based on observations, interviews and record reviews, residents were offered afternoon snacks. In addition, the identified resident's medical record contained documentation that the resident refused the afternoon milkshake several times and told staff the milkshake would be requested when the resident wanted it.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The resident did not receive Zinc Sulfate for several days after admission.

FINDINGS #4:

Based on record review and interview with the Director of Nursing, Zinc Sulfate was not available for administration to the identified resident. The allegation was substantiated and the deficient practice was cited at F 431.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The facility discontinued the resident's Calcium/Magnesium/Zinc supplement, which was "not allowed."

FINDINGS #5:

The identified resident's medical record documented a supplement with the combination calcium/magnesium/zinc/vitamin D twice a day was included in the admission orders. The day after admission, a Nurse Practitioner discontinued the combination supplement altogether. However, the combination supplement was reordered later that same day. The combination supplement was administered to the resident after that.

Joseph Rudd, Administrator  
October 7, 2015  
Page 4 of 9

Based on review of the medical records of several residents and the facility's grievance files, the allegation was substantiated and the deficient practice was cited at F 431.

**CONCLUSION:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #6:**

The resident's left knee became swollen and hot to the touch.

**FINDINGS #6:**

Per review of the identified resident's medical record, an orthopedic physician examined the resident's knee when it was swollen and hot to the touch. The physician documented the symptoms were expected and "appears to be normal." The allegation was not substantiated and deficient practice was not cited.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #7:**

The resident's pain was not controlled. Two days after admission, the resident went from 5:15 AM until dinner with no pain medication. The resident then began to experience severe leg cramps. Only when directed by the resident's family member did the nurse realize the resident had a medication order for the cramps, and provided it. The resident also experienced a delay receiving pain medication two days later.

**FINDINGS #7:**

The identified resident's medical record documented he/she was able to make his/her needs known. It also documented that as needed, pain medication was administered when the resident complained of pain and requested the medication two, and four days after admission.

The allegation was not substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #8:**

After receiving pain and anti-anxiety medications, the resident was too sleepy to eat.

Joseph Rudd, Administrator

October 7, 2015

Page 5 of 9

**FINDINGS #8:**

The identified resident's meal intake records documented the resident ate 25% of the evening meal and 100% of the bedtime snack on the day in question. There was no documented evidence the resident was too sleepy to eat after a pain medication and an anti-anxiety medication were administered.

Based on the record review, the allegation could not be substantiated, therefore deficient practice was not cited.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #9:**

During an identified resident's first care conference after admission, the resident's family member expressed dissatisfaction with the care the resident received. The social worker was present, made notes, but did not offer to move the resident to another facility.

**FINDINGS #9:**

The identified resident, family member, social worker, nurse, two therapists and activity staff attended the resident's first care conference after admission. The social worker documented the conference and noted the resident asked to utilize home health services after discharge and that pain medication be scheduled. The social worker noted the spouse was concerned about weight loss and increased redness and swelling in the resident's knee. The concerns were addressed during the conference. The knee was assessed as less red and swollen, education was provided regarding weight loss related to edema and fluid loss, and an order for scheduled pain medication was requested.

Based on record review and the facility's grievance investigation, concerns were voiced during the care conference. The allegation was substantiated, however, deficient practice was not identified or cited.

**CONCLUSION:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #10:**

On the fourth evening after admission, the identified resident was offered two meals for dinner, which was inconsistent with the diet order.

**FINDINGS #10:**

The identified resident's transfer orders to the facility included a general diet with six meals a day. Meal intake records documented the resident ate 100 percent of the evening meal on the fourth day after admission.

Joseph Rudd, Administrator  
October 7, 2015  
Page 6 of 9

Per observations and interviews, two meals during the same meal service were not provided unless requested.

The allegation could not be substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #11:**

The identified resident's knee was "forced back to get a better reading of improvement."

**FINDINGS#11:**

The identified resident's medical record documented a physical therapist had the resident perform active range of motion and assisted range of motion in order to measure extension and flexion of the knee joint. The resident was instructed to stop the therapist if needed due to pain. Additionally, the orthopedic surgeon documented improved knee range of motion four days after admission to the facility.

Therapy sessions with residents were observed and several residents and staff, including physical therapist, were interviewed. There were no observations or reports of forced therapy.

The allegation could not be substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #12:**

The identified resident's knee was again painful and swollen. The facility scheduled a "test for blood clots" to take place the next day. The resident's family member had not been informed of this appointment until dinner time the night before the appointment.

**FINDINGS #12:**

The identified resident's medical record contained documentation that the resident's family member was informed of the scheduled test the evening before the appointment. Per interviews with several residents and two family members, notification to family members regarding new orders and tests was not identified as a concern.

Review of the facility's grievance files revealed that notification to family members regarding new orders and tests was not identified as a concern.

Joseph Rudd, Administrator  
October 7, 2015  
Page 7 of 9

The allegation was substantiated, based on the interviews and grievance file reviews, deficient practice was not identified or cited.

**CONCLUSION:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #13:**

The identified resident's family member requested the resident be moved to another facility due to nutritional concerns and because the resident's knee had become swollen and required further testing. The transfer was delayed a day due to lack of beds available at the receiving facility. The resident's family member was informed at 11:00 AM on the day of transfer that a bed was available and information was requested at 9:00 AM but the facility had not provided it.

**FINDINGS #13:**

The identified resident's medical record documented the facility's social worker communicated with the receiving facility the day before discharge and sent required information to the receiving facility on the day of discharge. It also contained documentation that the resident was discharged from the facility at 3:20 PM.

Per interviews with facility staff, including the social worker, the facility expedited the discharge as quickly as possible.

The facility's grievance investigation noted the facility's social worker was notified at 2:20 PM on the day of discharge that the resident was approved for admission to the receiving facility.

The allegation could not be substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #14:**

The identified resident left the facility at 10:15 AM for an ultrasound appointment but the orders were not sent with the resident. By noon, the orders still had not been received. The resident was sent to the appointment with no lunch, so the resident's family member provided a power bar and a soda. The resident returned to the facility at 2:15 PM and was given pain medication on an empty stomach. The resident's family member was told the kitchen was closed at that time.

**FINDINGS #14:**

The identified resident's medical record documented he/she had an ultrasound test on the day in question and received a pain medication at 3:00 PM that afternoon.

Joseph Rudd, Administrator  
October 7, 2015  
Page 8 of 9

Per interviews with residents, family members and staff, no concerns were identified regarding appointments outside the facility, food availability, or pain medications.

The facility's investigation documented that on the day of the ultrasound, the resident left the facility at 10:30 AM and the ultrasound provider notified the facility at 1:00 PM that clarification of the ultrasound order was needed. The physician was contacted and the clarification was obtained and sent to the ultrasound provider.

The allegation was substantiated, however deficient practice was not identified or cited.

**CONCLUSION:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #15:**

The resident weighed 234 pounds at the time of admission to the facility. The resident weighed 231 pounds three days later and the day after discharge the resident weighed 228 pounds.

**FINDINGS #15:**

The identified resident's medical record documented the resident was admitted to the facility with lower extremity edema, was on a diuretic, and lost three pound in five days.

The allegation was substantiated., however deficient practice was not identified or cited.

**CONCLUSION:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #16:**

There are not enough staff to ensure charting and cares are completed timely.

**FINDINGS #16:**

Based on review of nursing hours records and the medical records of several residents, observations and interviews, the allegation was not substantiated.

**CONCLUSION:**

Unsubstantiated. Lack of sufficient evidence.

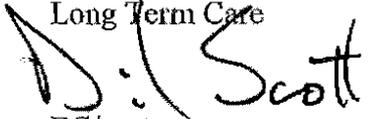
Joseph Rudd, Administrator  
October 7, 2015  
Page 9 of 9

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

David Scott, RN, Supervisor  
Long Term Care

  
DS/pmt



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October 6, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey was conducted at Apex Center:

The following documents were reviewed during the survey:

- The medical record of the identified resident;
- Twenty three other residents were reviewed for Quality of Care concerns;
- Resident Council Meeting minutes from July 2014 to June 2015;
- The facility's Grievances from January 2015 to July 2015;
- The facility's Incident and Accident reports from August 2014 to July 2015; and
- The facility's Reportable Investigation records from June 2014 to July 2015.

The following interviews were completed:

- Four residents;
- Two resident advocates;
- Six residents in the Resident Group;
- The Assistant Director of Nursing, the Unit Manager; and,
- The Director of Nursing were interviewed regarding Quality of Care concerns.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007052**

**ALLEGATION #1:**

A resident advocate requested that a prescribed sleeping medication not be administered to a resident related to safety concerns.

**FINDINGS #1:**

It was determined based on resident and staff interviews and records review the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

- Residents rooms were cluttered, dirty, and in "disarray."
- Dirty full urinals left in resident rooms for extended periods of time.

**FINDINGS #2:**

Based on observation, Resident Council minutes, resident group interview, and staff interview, it was determined the facility failed to ensure:

- A toilet was cleaned in two sampled resident's bathrooms;
- The floors in the facility were clean, free of debris and in good repair;
- Trash was picked up outside of the facility exits;
- The shower stall floors in hallways were cleaned;
- Hand sanitizer dispensers, fire extinguisher boxes, thermostat covers, and paper towel dispensers were free of dust and grease build-up;
- A smoking apron in the smoking area was free from stains; and,
- A refrigerator in a sampled resident's room was free from spilled liquids, expired food, and temperatures were documented.

It was determined the facility did not ensure resident rooms, bathrooms, and common areas were kept clean and free from lingering odors. Therefore, this allegation was substantiated and cited at F253.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

An identified resident engaged in activities which were inconsistent with physician-ordered sternal precautions.

FINDINGS #3:

The facility did not clarify and/or implement a resident's order for sternal precautions with the surgeon. Failure to receive clarification led to the resident performing tasks which were contraindicated. Therefore, this allegation was substantiated and cited a F-309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

A Resident advocate was not notified when a resident experienced a change of condition on two separate occasions.

FINDINGS #4:

The identified resident's medical record and twenty two other sampled resident's records were reviewed and did not identify concerns related to resident advocates not receiving notification.

Four resident advocates, two residents, and six residents in the Resident Group meeting were interviewed and did not express concerns related to notification.

Twenty two sampled resident records and grievances were reviewed and did not document concerns related to notification.

It could not be determined the facility had not notified resident advocates when a resident experienced a change in condition. Therefore, the allegation was unsubstantiated and no deficient practice was cited.

ALLEGATION #5:

A resident had bloody drainage from their surgical drain tube on several occasions.

FINDINGS #5:

The resident's medical record was reviewed and documented the identified concern had been addressed by the facility's Medical Director and the resident's out patient provider. The medical record documented the drain tube was being monitored regularly by nursing staff.

The Unit Manager and the Director of Nursing were interviewed and confirmed the concern had been reported to the facility. The Unit Manager confirmed the Medical Director had been notified and the drain tube was being monitored regularly.

It could not be determined the facility failed to drain the tube consistently. No deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

A resident's call light did not work, it was replaced, however the non-working one was left in the resident's room. Call light response times were slow.

FINDINGS #6:

During the survey, call lights were observed to be in proper working order and were answered in within an appropriate amount of time.

The facility's call light audits were reviewed and did not identify concerns related to excessive staff response times.

Resident Council Meeting minutes and Grievances were reviewed from July 2014 to June 2015 and when/if call light issues were identified by the group the facility was notified and addressed the concerns.

Four residents and two resident advocates were interviewed and did not verbalize concerns related to call lights.

Joseph Rudd, Administrator  
October 6, 2015  
Page 5 of 6

The allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Bed and pillows were old, uncomfortable, dirty, and disrepair.

FINDINGS #7:

It was determined the facility failed to provide linen in good repair for resident use. The allegation was substantiated and cited at F254.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #8:

On May 5, 2015, the facility did not have enough staff on evening shift to meet resident needs.

FINDINGS #8:

Resident Council Meeting minutes and Grievances were reviewed from July 2014 to June 2015 and did not identify concerns related to inadequate staffing on the evening shift.

The facility's staffing schedules were reviewed from April 2015 to June 2015 and did not identify concerns related to inadequate staffing on the evening shifts.

Four residents and two resident advocates were interviewed and did not verbalize concerns related to staffing on the evening shift.

The allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Joseph Rudd, Administrator  
October 6, 2015  
Page 6 of 6

ALLEGATION #9:

The facility tried to dissuade a resident's advocate from taking the resident home on a Friday. The resident advocate felt misled when filling out discharge paperwork.

FINDINGS #9:

Review of the resident's medical record documented the resident's advocates requested the discharge on the same day the resident discharged. The record documented the facility had set up coordinated care services for the resident after discharge. The requested services would not be available to the resident until Monday of the following week. The resident advocates were informed services would not be available and the facility requested the resident remain in the facility. The resident and resident's advocates declined and the resident discharged on Friday.

It was determined the facility had encouraged the resident to stay there through the weekend to ensure coordinated services would be available on Monday. The allegation was unsubstantiated and no deficient practice was cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

FILE COPY

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6628  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

August 11, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey of July 13 to July 17, 2015.

Residents were observed for oxygen needs during the survey;

The following documents were reviewed:

- The medical record of the identified resident;
- 23 other residents' records were reviewed for Quality of Care concerns;
- The facility's Grievance file from January to July 2015;
- Resident Council minutes from July 2014 to June 2015;
- The facility's Incident and Accident reports from August 2014 to July 2015; and,
- The facility's Allegation of Abuse reports from June 2014 to July 2015.

The following interviews were completed:

- Four residents were interviewed regarding Quality of Care concerns;
- Two residents' family members were interviewed regarding Quality of Care concerns;

Joseph B. Rudd, Administrator  
August 11, 2015  
Page 2

- Six residents in the Resident Group were interviewed regarding Quality of Care concerns;
- Three nurses were asked about oxygen usage for residents; and,
- The Director of Nursing Services was interviewed regarding Quality of Care concerns.

The complaint allegations, findings and conclusions are as follows:

**Complaint #6992**

**ALLEGATION #1:**

The complainant stated an identified resident's oxygen canister was found empty.

**FINDINGS #1:**

The identified resident no longer resided in the facility at the time the complaint was investigated.

The allegation was substantiated with other residents during the survey and the facility was cited at F328.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The complainant stated an identified resident experienced an increase in pain after the facility's van made a sudden stop.

**FINDINGS #2:**

The identified resident no longer resided in the facility at the time the complaint was investigated.

The allegation was substantiated and the facility was cited at F323.

**CONCLUSIONS:**

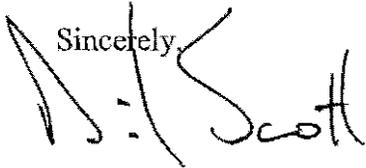
Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

Joseph B. Rudd, Administrator  
August 11, 2015  
Page 3

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
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FILE COPY

August 10, 2015

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

Provider #: 135079

Dear Mr. Rudd:

On July 17, 2015, an unannounced on-site complaint survey was conducted at Apex Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted on July 13 to July 17, 2015.

The following observations were completed:

- The entire facility was observed for cleanliness;
- Call light accessibility, belongings on the floors, care directive signs.

The following documents were reviewed:

- The medical record of the identified resident;
- 23 other residents' records were reviewed for Quality of Life concerns;
- The facility's Grievance file from January to July 2015;
- Resident Council minutes from July 2014 to June 2015;
- The facility's Incident and Accident reports from August 2014 to July 2015; and,
- The facility's Allegation of Abuse reports from June 2014 to July 2015.

The following interviews were completed:

- Four residents were interviewed regarding Quality of Life concerns;
- Two residents' family members were interviewed regarding Quality of Life concerns;
- Six residents in the Resident Group were interviewed regarding Quality of Life concerns;
- Two housekeepers and the Director of Environmental services were interviewed regarding cleaning issues; and,
- The Director of Nursing Services was interviewed regarding Quality of Life concerns.\*

The complaint allegations, findings and conclusions are as follows:

#### **Complaint #6800**

##### **ALLEGATION #1:**

The complainant stated eyeglasses for an identified resident had been treated carelessly and were found on the floor, in spilt liquids and inappropriate places.

##### **FINDINGS #1:**

Observations were made in the identified resident's room and eight other residents' rooms. There were no observations of eyeglasses found in inappropriate areas.

Two housekeepers were interviewed regarding cleaning techniques and they said residents' belongings were treated respectfully;

Four residents interviewed expressed no concerns for eyeglasses;

Two residents' family members interviewed expressed no concerns for eyeglasses; and,

Six residents in the Resident Group interviewed expressed no concerns for eyeglasses.

Based on observations; resident, family and staff interviews, it was determined the allegation could not be substantiated.

##### **CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

##### **ALLEGATION #2:**

The complainant stated there were spilt liquids and other substances found on the resident's room

Joseph B. Rudd, Administrator  
August 10, 2015  
Page 3

and facility's floors that had not been cleaned for long periods.

**FINDINGS #2:**

The allegation was substantiated and the facility was cited at F253.

**CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #3:**

The complainant stated an identified resident's personal belongings, including clothing, were often found on the floor.

**FINDINGS #3:**

The allegation was substantiated for another resident during the survey and the facility was cited at F441.

**CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #4:**

The complainant stated an identified resident's call light was found on the floor and/or placed where the resident could not reach it.

**FINDINGS #4:**

Call light placement was observed for all residents in the facility and all residents had call lights within reach.

The facility's Grievance file from January to July 2015 was reviewed and call light placement was not identified as an issue. Resident Council minutes from July 2014 to June 2015 were reviewed and call light placement was not identified as an issue.

Four residents were interviewed and call light placement was not identified as an issue.

Two residents' family members were interviewed and call light placement was not identified as an issue; and, six residents in the Resident Group were interviewed and call light placement was not identified as an issue.

Joseph B. Rudd, Administrator  
August 10, 2015  
Page 4

Based on observations, records reviewed, residents and family interviews, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated there was a sign above identified resident's bed, which included care directives.

FINDINGS #5:

The allegation was substantiated and the facility was cited at F241.

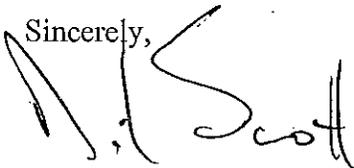
CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF  
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March 8, 2016

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted July 13, 2015 to July 17, 2015.

The clinical record of the identified resident and twenty-three other residents were reviewed regarding quality of life and quality of care. The facility's Grievance files for January to July 2015 were reviewed, as were Resident Council meeting minutes for July 2014 to June 2015, Incident and Accident reports for August 2014 to July 2015, Abuse Allegation reports for June 2014 to July 2015, and nurse staffing records for November 2014 to July 2015.

Interviews were conducted with four residents, two family members, and six residents in a group interview about quality of life and quality of care. Three licensed nurses, two Certified Nursing Assistants, the Director of Nursing Services, the Social Worker, and the Administrator were interviewed about quality of life and quality of care.

Licensed Nurses, Certified Nursing Assistants, and therapy staff were observed as they provided care and assistance to residents.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006938**

**ALLEGATION #1:**

The complainant stated the identified resident experienced an unwitnessed fall from a wheelchair and was transported to a local hospital where he/she was admitted for facial trauma and a fracture to the second cervical vertebrae.

**FINDINGS:**

On the morning of the incident, the resident was awake and wanted to get up for breakfast. The resident's Nutrition Care Plan documented staff were to get the resident up for meals. A Certified Nursing Assistant helped the resident to dress and get into the wheelchair, then took the resident to the sink to finish grooming. At this time, the Certified Nursing Assistant heard another resident's bed alarm sound and left to assist the other resident. A Licensed Nurse observed the resident in the wheelchair by the sink while on the way to give medications to other residents. The resident was alone for approximately ten to fifteen minutes before he/she was found on the floor by the sink. The nurse assessed the resident, vital signs were checked, and neurological checks were initiated. The resident was assisted from the floor with a mechanical lift. The physician was notified and gave an order to transfer the resident to a hospital for evaluation. In the month prior to the fall, the resident had demonstrated safe and effective use of the wheelchair, with no concerns related to positioning or safety. It was determined the resident fell asleep while sitting in the wheelchair. The allegation was not substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility lost the identified resident's upper denture, which had been purchased with private funds.

**FINDINGS:**

Based on record review and staff interviews, the allegation was substantiated and the facility was cited at F411.

Joseph Rudd, Administrator  
March 8, 2016  
Page 3 of 3

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "S" and "C".

David Scott, R.N., Supervisor  
Long Term Care

DS/lj



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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

March 8, 2016

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted July 13, 2015 to July 17, 2015.

The clinical record of the identified resident and twenty-three other residents were reviewed regarding quality of life, quality of care, and the environment. The facility's Grievance files for January to July 2015 were reviewed, as were Resident Council meeting minutes for July 2014 to June 2015, Incident and Accident reports for August 2014 to July 2015, Abuse Allegation reports for June 2014 to July 2015, and nurse staffing records for November 2014 to July 2015.

Interviews were conducted with four residents, two family members, and six residents in a group interview about quality of life, quality of care, and the environment. Three licensed nurses, two Certified Nursing Assistants, the Director of Nursing Services, the Social Worker, and the Administrator were interviewed about quality of life and quality of care. The Director of Environmental Services and two housekeepers were interviewed about the facility environment.

An initial tour of residents' rooms was conducted immediately after the survey team entered the facility on July 13, 2015. In addition, staffs' responses to call lights and the condition of bed linens was observed throughout the survey.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007006**

**ALLEGATION #1:**

Clean sheets are placed on top of wet, soiled sheets.

**FINDINGS:**

There were no observations of clean sheets placed on top of wet, soiled sheets. However, the allegation was substantiated related to other linen issues and the deficient practice was cited a F254.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #2:**

Staff did not respond to a call light for twenty-five minutes.

**FINDINGS:**

Based on observations and interviews with residents and family members, it was determined the call lights were answered timely. In addition, record reviews, including staffing hours and grievance files, did not reveal deficient practice. The allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

Blood was not drawn as requested.

**FINDINGS:**

Based on review of the identified resident's clinical record and staff interview, it was determined the physician ordered non-urgent blood tests, which were completed on the next scheduled day for blood work to be done in the facility. During interviews with individual residents, family members, and the Resident Group, concerns about blood testing were not expressed. Review of

Joseph Rudd, Administrator  
March 8, 2016  
Page 3 of 3

the medical records of the other residents and grievance files revealed concerns about blood testing were not identified. The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The resident's chest was congested and there was a concern the resident might get pneumonia.

FINDING #4:

The medical record documented the identified resident's lung sounds were clear during the facility stay and that a chest x-ray was ordered and completed one day after the resident complained of a sore throat. The x-ray was negative. The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

David Scott, R.N., Supervisor  
Long Term Care

DS/lj



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March 7, 2016

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

Provider #: 135079

Dear Mr. Rudd:

On **July 17, 2015**, an unannounced on-site complaint survey at Apex Center. The complaint was investigated in conjunction with the facility's Recertification and State Licensure survey conducted July 13, 2015 to July 17, 2015.

The clinical record of the identified resident and twenty-three other residents were reviewed regarding quality of life, quality of care, and admission paperwork. The facility's Grievance files for January to July 2015 were reviewed, as were Resident Council meeting minutes for July 2014 to June 2015, Incident and Accident reports for August 2014 to July 2015, Abuse Allegation reports for June 2014 to July 2015, and nurse staffing records for November 2014 to July 2015.

Interviews were conducted with four residents, two family members, and six residents in a Resident Group interview about quality of life, quality of care, the environment, and the admission process. Three licensed nurses, two Certified Nursing Assistants, the Director of Nursing Services, the Social Worker, and the Administrator were interviewed about quality of life and quality of care. Three therapy staff were interviewed about therapy issues. The Licensed Nurses and the Business Office Manager were interviewed about the admission process. The Director of Environmental Services and two housekeepers were interviewed about the facility environment.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00007095**

**ALLEGATION #1:**

A copy of an identified resident's admission papers were not provided.

**FINDINGS:**

An initial tour of residents' rooms was conducted immediately after the survey team entered the facility on July 13, 2015, and the environment of the facility was observed throughout the survey.

Licensed Nurses, Certified Nursing Assistants, and therapy staff were observed as they provided care and assistance to residents.

Based on the observations, record reviews, and interviews, the allegation was not substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The identified resident was found laying across the bed and with feces everywhere.

**FINDINGS:**

Based on the initial tour of the facility, observations during survey, and interviews with staff, Resident Group, and the group interview with residents, it was determined the facility did not ensure cleanliness was maintained in residents' rooms, restrooms, and other areas of the facility. The allegation was substantiated and cited at F 253.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #3:**

The Reporting Party was told the the facility had one staff member available overnight to take care of the identified resident.

FINDINGS:

Individual residents, residents in the Resident Group interview with surveyors, and family members, did not express concerns about inadequate staffing on the night shift.

Review of the Resident Council meeting minutes, Grievance files, and Nurse Staffing records revealed there were no night shift staffing concerns.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The identified resident had diarrhea for twenty-one hours without treatment from 5:00 pm on the day of admission until 2:00 pm the next day.

FINDINGS:

The identified resident's clinical record documented the resident had loose bowel movements then diarrhea during the twenty-one hours after admission. The record documented that after the second episode of diarrhea, an anti-diarrhea medication was administered at 11:00 am the day after admission.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The identified resident was dehydrated from diarrhea and started losing the ability to swallow.

A speech therapist evaluated the resident and determined there was too much risk of aspiration. The speech therapist put the resident on nothing by mouth (NPO). Nothing was offered as an alternative solution for eating and drinking.

Joseph Rudd, Administrator  
March 7, 2016  
Page 4 of 4

FINDINGS:

The identified resident's record documented a speech therapist assessed the resident to be at risk for aspiration and recommended nothing by mouth. The record documented the physician ordered small amounts of fluids by mouth as tolerated/desired and that the resident was able to take a few sips at a time. The record also documented that two types of feeding tubes were discussed with the resident's advocates who chose end of life care instead.

Concerns about fluids and food by mouth were not verbalized during the interviews with the individual residents, the group of residents, or the family members.

The allegation was unsubstantiated and no deficient practice was identified.

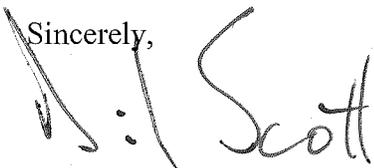
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large, prominent "S" at the beginning.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj