



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

February 18, 2016

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

Provider #: 135079

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

Dear Mr. Rudd:

On **February 9, 2016**, a Facility Fire Safety and Construction survey was conducted at **Apex Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE**

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completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 2, 2016**. Failure to submit an acceptable PoC by **March 2, 2016**, may result in the imposition of civil monetary penalties by **March 22, 2016**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 15, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 15, 2016**. A change in the seriousness of the deficiencies on **March 15, 2016**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 15, 2016**, includes the following:

Denial of payment for new admissions effective **May 9, 2016**.

42 CFR §488.417(a)

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

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 9, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

BFS Letters (06/30/11)

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

This request must be received by **March 2, 2016**. If your request for informal dispute resolution is received after **March 2, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a horizontal line that ends in an arrowhead pointing to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

PRINTED: 02/17/2016
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 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2016
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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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(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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K 000	INITIAL COMMENTS The facility consists of two Type V (111) buildings that are separated by a breezeway. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinkled and equipped with a fire alarm/smoke detection system which includes smoke detection in sleeping rooms as well as corridors and open spaces. The facility is licensed for 148 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on January 9, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis HealthCare - Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the	K 018	RESIDENT SPECIFIC On or before February 26, 2016 the doors on the supply room in the East Mechanical hallway and on resident room 203 have been adjusted by the Facility Maintenance Director or Designee so that they close and latch properly. OTHER RESIDENTS All other doors in the facility have been assessed, on or before	MAR 01 2016 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>D B Edd</i>	TITLE Administrator	(X6) DATE 2/26/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	<p>Continued From page 1</p> <p>door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely between compartments. This deficient practice has the potential to affect 18 residents, staff, and visitors on the date of survey. The facility is licensed for 148 SNF/NF beds with a census of 81 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on February 9, 2016 at approximately 3:15 PM, observation and operational testing of the Supply Room in the East Mechanical hallway revealed the door would not close properly leaving a 2 inch gap in between the leading edge of the door and the door frame. When asked, the Maintenance Supervisor stated the door was dragging due to the bottom of the door rubbing the floor.</p> <p>2.) During the facility tour on February 9, 2016 at approximately 3:35 PM, observation and operational testing of the door leading to room 203 revealed the door would not close and latch properly. When asked, the Maintenance supervisor stated the facility was unaware of the door not latching properly.</p> <p>Actual NFPA standard:</p>	K 018	<p>February 26, 2016 by the Facility Maintenance Director or Designee for compliance with Life Safety Code K018. Any door found to be misaligned or not closing correctly were repaired by the Facility Maintenance Director or Designee.</p> <p>FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with K018</p> <p>MONITORS Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit 4 doors in the facility to ensure proper operation of doors. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action.</p>	

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K 018	Continued From page 2 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain	K 018	DATE OF COMPLIANCE February 28, 2016 K062 RESIDENT SPECIFIC 1.) The Antifreeze sprinkler system has been inspected by Viking Sprinkler and the antifreeze solution percentage has been checked and included in the inspection report. 2.) The sprinkler heads in Room 704, 706, 605 and the East dining room have been cleaned by the Facility Maintenance Director or Designee on or before February 25, 2016. OTHER RESIDENTS Dirty sprinkler heads have the potential to affect all residents. On or before February 26, 2016 an audit was completed by the Facility Maintenance Director or Designee to identify dirty sprinkler heads throughout the facility. Any sprinkler heads identified as dirty were cleaned on or before February 26, 2016 by the Facility Maintenance Director or Designee.	

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K 018	Continued From page 3 flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with K062. Viking Sprinkler was educated on or before February 26 by the Facility Maintenance Director about the requirement to document the antifreeze solution percentage with each system check.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to maintain fire suppression systems could hinder system response during a fire event. This deficient practice affected 15 residents, staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 81 on the day of the survey. Findings include: 1) During review of facility fire suppression system inspection records on February 9, 2016 at approximately 9:45 AM, no documentation was provided indicating the antifreeze solution percentage inside the sprinkler system. When asked, the Maintenance Supervisor stated he was not aware of the requirement for antifreeze solution percentage. 2) During the facility tour on February 9, 2016 at approximately 1:30 PM, observation of installed fire suppression system sprinkler heads revealed	K 062	MONITORS 1.) For the next year the Maintenance Director will inspect the quarterly fire sprinkler inspection sheets to verify that the antifreeze percentage is included. 2.) Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit sprinkler heads in 4 areas of the facility for any corrosion, foreign material, paint, and physical damage and to ensure they are installed in the proper orientation. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as	

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K 062	<p>Continued From page 4 the following:</p> <ul style="list-style-type: none"> a. One (1) painted sprinkler head located in the closet of room 704 b. One (1) painted sprinkler head located in the closet of room 706 c. One (1) painted sprinkler head located in room 605 d. One (1) painted sprinkler head located in the East dining room <p>When asked, the Maintenance Supervisor stated the facility was not aware of the painted sprinkler heads.</p> <p>Actual NFPA standard:</p> <p>1.) NFPA 25</p> <p>2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]</p> <p>2.) NFPA 25</p> <p>2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall</p>	K 062	<p>part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action.</p> <p>DATE OF COMPLIANCE February 28, 2016</p> <p>K066 RESIDENT SPECIFIC The equipment identified as inadequate in the Resident Smoking area has been removed and replaced by a self-closing cover ashtray by the Facility Maintenance Director or Designee on or before February 26, 2016.</p> <p>OTHER RESIDENTS Not having the proper equipment in the smoking areas has the potential to affect all residents in the unit. On or before February 26, 2016 the Facility Maintenance Director or Designee has inspected all facility smoking area for proper equipment. No other inadequate equipment was identified.</p>	

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K 062	Continued From page 5 be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with K066	
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide metal containers with self-closing devices in designated smoking areas. The deficient practice affected residents that utilize	K 066	MONITORS Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit all 3 smoking areas for proper equipment and that it is in good working condition. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. DATE OF COMPLIANCE February 28, 2016	

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K 066	<p>Continued From page 6</p> <p>the smoking area and staff on the day of survey. The facility is licensed for 148 SNF/NF beds with a census of 81 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on February 9, 2016 at approximately 3:00 PM, observation revealed the residents designated smoking area outside the East Wing was not equipped with a metal container with a self-closing cover. Upon further investigation of the trash receptacle revealed cigarette butts thrown into the trash that contained combustible materials. When asked, the Maintenance Supervisor stated the facility was not aware the smoking areas required a self-closing metal container.</p> <p>Actual NFPA standard:</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct</p>	K 066	<p>K070</p> <p>RESIDENT SPECIFIC</p> <p>On or before February 26, 2016 the portable space heater located in room 614, Physical Therapy office was removed by the Facility Maintenance Director or Designee.</p> <p>OTHER RESIDENTS</p> <p>Portable space heaters in resident sleeping areas have the potential to affect all residents in that sleeping area. On or before February 26, 2016 the Facility Maintenance Director or Designee has inspected all rooms in resident sleeping areas for portable space heaters and for any other fire risk. Any portable space heaters found have been removed from those sleeping areas and any other fire risk has been mitigated by the Facility Maintenance Director or Designee on or before February 26, 2016.</p> <p>FACILITY SYSTEMS</p> <p>The Facility Maintenance Director was educated, on or before February 26, 2016 by the corporation Regional Plant Manager regarding the</p>	

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K 066	Continued From page 7 supervision.	K 066	components of compliance with K070.	
K 070 SS=E	<p>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prohibit portable space heaters in sleeping areas. Portable space heaters in sleeping areas is considered a significant risk due to the history of fires caused by space heaters. This deficient practice affected 13 residents, staff, and visitors on the day of survey. The facility is licensed for 148 SNF/NF beds with a census of 81 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on February 9, 2016 at approximately 2:00 PM, observation revealed a portable space heater located in room 614, Physical Therapy office. This office was located inside a resident sleeping area. When asked, the Maintenance Supervisor stated the facility was unaware the room was considered in the resident sleeping area.</p>	K 070	<p>MONITORS</p> <p>Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit 4 rooms in resident sleeping areas for any use of portable space heaters. Any found will be immediately removed and this individual who placed the heater will be educated. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action.</p> <p>DATE OF COMPLIANCE February 28, 2016</p> <p>K072 RESIDENT SPECIFIC On or before February 26, 2016 the obstructions in the East</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2016
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
K 070	Continued From page 8 Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent the safe evacuation of occupants during an emergency. This deficient practice has the potential to affect residents, staff and visitors utilizing the corridor on the day of survey. The facility is licensed for 148 SNF/NF beds with a census of 81 on the day of survey. Findings Include: During the facility tour on February 9, 2016 at approximately 9:15 AM, observation revealed that the East Mechanical corridor means of egress was obstructed by two beds and a food cart. Upon further observation at 3:00 PM, observation	K 070	Mechanical corridor have been removed by the Facility Maintenance Director or Designee. OTHER RESIDENTS Obstructions in egress corridors have the potential to affect all residents. On or before February 26, 2016 the Facility Maintenance Director or Designee has inspected all egress corridors for any kinds of obstructions, and removed any obstructions found. FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with K072. The Facility Maintenance Director or Designee has educated the facility department managers of the need to ensure that egress corridors are maintained clear of obstructions. MONITORS Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit all egress	
K 072 SS=D		K 072		

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K 072	Continued From page 9 revealed the 2 beds and food cart was still stored in the corridor blocking egress. When asked, the Maintenance Supervisor stated the facility was unaware of the obstructed means of egress. Actual NFPA Standard: NFPA 101, 7.1.10 Means of Egress Reliability, 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	corridors for obstructions. Any obstructions found will be removed and the individual who placed the obstruction in the corridor will be educated. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. DATE OF COMPLIANCE February 28, 2016		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke partitions were maintained. Failure to maintain smoke partitions could allow smoke and dangerous gases to pass freely between compartments affecting egress during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 148 SNF/NF beds and had a census of 81 on the day of the survey. Findings include: During the facility tour on February 9, 2016 at approximately 1:15 PM, observation of the Soiled Linen room in the 800 hallway revealed an approximate 1 inch circular hole in the ceiling. When asked, the Maintenance Supervisor stated the facility believes the hole was created when the new light fixture was installed Actual NFPA standard:	K 130	K130 RESIDENT SPECIFIC The penetration in the smoke partition in the soiled linen room on the 800 hallway was repaired on or before February 26, 2016 by the Facility Maintenance Director or Designee. OTHER RESIDENTS Penetrations in smoke partitions have the potential to affect all residents in that unit. On or before		

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K 130	Continued From page 10 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke. 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception*: Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous	K 130	February 26, 2016 the Facility Maintenance Director or Designee has inspected the facility for smoke partition penetrations. Any penetrations found have been repaired on or before February 26, 2016 by the Facility Maintenance Director or Designee. FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with K130. The Facility Maintenance Director or Designee will monitor all work being completed through smoke partitions for proper penetration repair. MONITORS Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit 4 areas of the facility for any penetrations in any smoke partitions. Any that are found will be repaired and the results of these audits will be reported monthly for three months	

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K 130	Continued From page 11 membrane. (b) A smokelight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum. K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS=E Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical wiring was in accordance with the National Electrical Code. Exposure of open electrical connections, wiring, or improper use of flexible cords, could result in fires by arcing or electrocution. The deficient practice 13 residents, staff, and visitors on the date of survey. The facility has the capacity for 148 SNF/NF beds with a census of 81 the day of survey. Findings include: 1.) During the facility tour on February 9, 2016 at approximately 2:00 PM, observation revealed two Relocatable Power Taps daisy chained. When asked, the Maintenance Supervisor stated the facility was unaware of the daisy chained relocatable power taps. 2.) During the facility tour on February 9, 2016 at approximately 2:30 PM, observation of the electrical panel in hallway 500 revealed two blank covers missing exposing the interior of the electrical panel. When asked, the Maintenance Supervisor stated he was aware of the covers	K 130	to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. DATE OF COMPLIANCE February 28, 2016 K147 RESIDENT SPECIFIC On or before February 26, 2016 the following identified deficiencies have been corrected through removal, repair or replacement by the facility Maintenance Director or Designee. 1.) Daisy-chained relocatable power taps in the therapy office. 2.) The two missing blank covers in the 500 hall electrical panel. OTHER RESIDENTS All residents have the potential to be affected by Electrical wiring and equipment not in accordance with NFPA 70, National Electrical Code 9. 1.2. Areas of the facility have been audited by the Facility

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K 147	Continued From page 12 missing from the panel. Actual NFPA Standard: 1.) NFPA 70, 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code Also refer to UL Online Certifications Directory XBYS.GuidelInfo Relocatable Power Taps 2.) NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm	K 147	Maintenance Director or designee on or before February 26, 2016 to evaluate compliance with NFPA 70, National Electrical Code 9. 1.2. Any non-compliant findings were corrected. FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with K147. The Facility Maintenance Director or Designee has educated the facility department managers of the need to ensure that power taps are used appropriately throughout the facility. MONITORS 1.) Beginning the week of February 29, 2016 the Facility Maintenance Director or designee will audit 4 electrical panels of the facility each week for four weeks and then monthly for two months to ensure that areas of the facility are in compliance with NFPA 70, National Electrical Code 9. 1.2. Any non-compliant findings will be corrected.	

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K 147	Continued From page 13 (1/4 in.) from the outer surface of the enclosure.	K 147	2.) Beginning the week of February 29, 2016 the Facility Maintenance Director or designee will audit 4 areas of the facility each week for four weeks and then monthly for two months to ensure that areas of the facility are in compliance with NFPA 70, 400-8. Any non-compliant findings will be corrected. The results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. DATE OF COMPLIANCE February 28, 2016	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2016
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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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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The facility consists of two Type V (111) buildings that are separated by a breezeway. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinkled and equipped with a fire alarm/smoke detection system which includes smoke detection in sleeping rooms as well as corridors and open spaces. The facility is licensed for 148 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on January 9, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	C 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> <p>C386 RESIDENT SPECIFIC The penetration on the outside overhang of the exit door at the end of 700 hallway was repaired on or before February 26, 2016 by the Facility Maintenance Director or Designee.</p> <p>OTHER RESIDENTS Any penetration in the exit door overhangs of the building could affect all residents within that unit. On or before February 26, 2016 the Facility Maintenance Director or Designee has inspected all exit door overhangs for penetrations. Any penetrations found have been</p>	
C 386	<p>02.120,03,a Building/Equipment in Good Repair</p> <p>a. The building and all equipment shall be in good repair. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building was in good repair. Failure to ensure the building was in good repair could allow rodents, insects and other animals to enter the facility affecting fire alarm and fire suppression system components. This deficient practice affected residents staff and visitors in the 700 hallway on the day of survey. The facility is licensed for 148 SNF/NF beds with a census of</p>	C 386		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrative	2/26/16

Bureau of Facility Standards

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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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C 386	Continued From page 1 81 on the date of survey. Findings include: During the facility tour on February 9, 2016 at approximately 1:30 PM, observation of the southwest exit in the 700 hallway revealed a 2-3 inch circular hole in the overhang just outside the exit door. When asked, the Maintenance Supervisor stated the facility was unaware of the hole in the overhang. Actual IDAPA standard: IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities 120. EXISTING BUILDINGS 03. General Building Requirements. An existing facility shall be of such character to be suitable for use as a facility. The facility will be subject to approval by the Department. Other requirements are as follows: a. The building and all equipment shall be in good repair.	C 386	repaired on or before February 26, 2016. FACILITY SYSTEMS The Facility Maintenance Director was educated on or before February 26, 2016 by the corporation Regional Plant Manager regarding compliance requirements with C386. MONITORS Beginning the week of February 29, 2016 for four weeks and then monthly for two months the Facility Maintenance Director or Designee will audit 4 exit door overhangs of the facility for any penetrations. Any that are found will be repaired and the results of these audits will be reported monthly for three months to the Administrator and to the Safety Committee, as part of the facility's Quality Assurance and Performance Improvement process. Identified non-compliance with the Life Safety Code will be addressed with corrective action. Date of Compliance February 28, 2016	