



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 22, 2016

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

Provider #: 135079

Dear Mr. Rudd:

On **July 1, 2016**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint investigation survey was conducted at the facility on June 30, 2016 and July 1, 2016.

The clinical records of the identified resident and five other residents were reviewed for quality of life, quality of care, and facility transportation out of the facility. The facility's out-of-facility appointments and transportation logs for December 2015 through February 2016 and June 2016 were reviewed. The facility's grievance files, incident and accident reports, and allegations of abuse investigations, for December 2016 through June 2016, were reviewed. In addition, the facility's policies and procedures for tobacco use/smoking and neurological assessments related to unwitnessed falls and falls with injury to the head, the van driver/transportation job description were reviewed.

Interviews were conducted with two residents regarding quality of life, quality of care, and facility transportation services. Interviews were also conducted with two licensed nurses, three Certified Nursing Assistants, and the Director of Nursing Services regarding quality of life, quality of care, and preparations for residents' out-of-facility appointments and transportation. In addition, the Ombudsman was interviewed as was one of two facility van drivers. The second van driver, was no longer employed by the facility and was not interviewed.

An initial tour of residents' rooms and common areas was conducted immediately after the survey team entered the facility on June 30, 2016, and the general resident population was observed

during the survey. The residents were observed to be dressed appropriately and without odors of urine while in- and out of their rooms.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007223

ALLEGATION:

An identified resident was dropped off on December 21, 2015 at a doctor's office with no pants, nothing but a towel draped over his legs, and smelled of urine. It was cold that day.

The identified resident was dropped off with papers. The resident was confused and did not know where he was, the name of his primary care provider, where he lived, other than there were four letters in the name of where he lived, or how to get back to where he lived.

The resident's left knee was swollen and painful to the touch. The resident said this was due to a fall.

FINDINGS:

The clinical record documented the identified resident was sent to an emergency room for evaluation within thirty minutes after a laceration to the head from an unwitnessed fall. The resident returned to the facility later that day and denied pain. Day two after the fall, the resident's left knee was swollen. The resident denied pain, refused pain medications, and refused to allow staff to assess the knee and range of motion. Day three after the fall, the left knee swelling persisted and the resident complained of pain but continued to refuse pain medications and assessments. Day four after the fall, a Nurse Practitioner ordered ice to the knee and left knee x-rays. X-rays done that day revealed a patella fracture with large joint effusion and soft tissue swelling. The resident was referred to an orthopedist with an appointment set for nine days after the fall. On day eight after the fall, the resident had an appointment with a general practitioner to establish new patient care and on day nine after the fall, the resident saw the orthopedist. During the time between the fall and the medical appointments, the resident's knee was swollen and he/she complained of pain but repeatedly refused physical assessments, pain medications, showers, and blood draws for laboratory tests.

The interviewed residents said that the nursing staff helped them to dress and prepare for out-of-facility appointments, the van drivers also ensured they were dressed and ready to go before transportation, the driver would drop them off or help them in- and out of doctors' offices if needed.

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The interviewed van driver said he would ensure residents were dressed appropriately and ready to go before transportation to appointments. The driver said he would drop off and pick up the independent residents, but would help resident's in- and out of doctors' offices when needed. The driver said if a resident needed more assistance and a family member or friend was not available, the facility would send a staff member to stay with the resident. The van driver said he was not the driver on duty when the identified resident's doctor's appointments occurred.

The interviewed Licensed Nurses and Certified Nursing Assistants said they ensured residents were dressed appropriately and ready to go prior to facility transportation for appointments.

The Director of Nursing Services said the identified resident refused to shower and insisted on wearing shorts, rather than pants, to the doctor appointments. The Director of Nursing Services said the resident was covered with a heavy blanket because he/she refused a coat or jacket.

The Ombudsman said she had talked with the social worker after the incident and the social worker has been very involved and intervened repeatedly when the identified resident refused assessments, showers, and medications.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor
Long Term Care

DS/lj

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

PRINTED: 08/08/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/01/2016
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	
F 000	<p>INITIAL COMMENTS</p> <p>A complaint investigation survey was conducted at the facility on 6/30/16 and 7/1/16. Deficient practice was not cited.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Leader Jenny Walker, RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

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.