



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

**CERTIFIED MAIL: 7012 1010 0002 0836 1796**

March 14, 2014

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

Provider #: 135079

Dear Mr. Rudd:

On **March 6, 2014**, a Complaint Investigation 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/or 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, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **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 3). **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date, to signify when you allege that each tag will be back in compliance.** WAIVER RENEWALS MAY BE REQUESTED ON THE PLAN OF CORRECTION. After each deficiency has been answered and dated, the administrator should sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in

Joseph B. Rudd, Administrator  
March 14, 2014  
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the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 27, 2014**. Failure to submit an acceptable PoC by **March 27, 2014**, may result in the imposition of civil monetary penalties by **April 16, 2014**.

The components of a Plan of Correction, as required by CMS include:

- 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 in place or what systemic change will you 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. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
  - a. Specify by job title, who will do the monitoring. It is important that the individual doing the monitoring have the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
  - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for "random" audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
  - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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 both the federal survey report, Form

Joseph B. Rudd, Administrator  
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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 **April 10, 2014 (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 **April 10, 2014**. A change in the seriousness of the deficiencies on **April 10, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 10, 2014** includes the following:

Denial of payment for new admissions effective **June 6, 2014**. [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 **September 6, 2014**, 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 Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

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

Joseph B. Rudd, Administrator  
March 14, 2014  
Page 4 of 4

Regional Office or the State Medicaid Agency beginning on **March 6, 2014** 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 noncompliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **March 27, 2014**. If your request for informal dispute resolution is received after **March 27, 2014**, 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,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj  
Enclosures

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

PRINTED: 03/12/2014  
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 03/06/2014
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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
F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint investigation survey of your facility.  The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator, and Sherri Case, LSW, QMRP.  The survey team entered the facility on 3/5/14 and exited the facility on 3/6/14.  Survey Definitions: DON = Director of Nursing Services CNA = Certified Nursing Assistant EUM = East Unit Manager	F 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."  <b>RECEIVED</b>  <b>APR 11 2014</b>	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  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.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, it was determined the facility failed to ensure an environment free of pervasive urine odors. This was true for 1 of 10 sampled residents (#1), 3 residents who wished to remain anonymous and any resident who resided on or wished to access another part of the facility via the 400 hall. This practice had the potential to cause embarrassment and/or harm as it affected how residents viewed themselves or their environment. Findings included:	F 252		F252 RESIDENT SPECIFIC FACILITY STANDARDS Resident #1's soiled clothing was immediately placed in a closed container by Housekeeping Staff to control any odor emanating from them on 3/6/14. The bathroom area was also deep cleaned by Housekeeping staff on 3/6/14. Resident #1's urostomy was changed the day prior 3/5/14 due to leakage and was assessed by the RN Unit Manger on 3/6/14 and was not leaking. She also evaluated the room

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  Administrator	(X8) DATE  3 24 14
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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.

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0891

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 03/06/2014
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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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F 252	Continued From page 1  Resident #1 was admitted to the facility on 4/5/11 with diagnoses which included spina bifida and neurogenic bladder.  The resident's Care Plan, dated 1/27/12, documented staff were to empty the resident's urostomy (artificial opening for urine) and record the output every day.  Upon entering the building on 3/5/14 at 1:15 p.m., two surveyors noted a smell of urine as they walked through the bridge (the hallway connecting the east and west side of the facility) and through the 400 hall. At 1:40 p.m. the smell of urine was still prevalent and stronger near Resident #1's room. When asked about the urine smell, the EUM stated the odor was common due to changing the resident's urostomy bag. The strong odor was still present at 4:00 p.m.	F 252	for odors at that time. Both room and resident were free from odors.  On 3/11/14 and again 3/25/14 Resident Council meeting discussed odors and indicated that they were unaware of any odor problems in the center, but were aware to report any persistent unpleasant odors to facility staff.  <b>OTHER RESIDENTS</b> On or before 3/18/2014 resident rooms, (including rooms of residents with urostomies), hallways and common areas in the center have been checked by the facility administrator for persistent odors. The root causes of any persistent odors identified were immediately corrected.	
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	On 3/6/14 at 9:05 a.m., Resident #1 stated she had knew her bathroom had an odor. At that time the surveyor checked the bathroom and noticed a strong smell of urine. An open laundry basket was observed sitting on a commode. The smell of urine was stronger near the laundry basket.  The smell of urine was documented in the 400 hall and bridge on 3/6/14 at 9:00 a.m., 9:15 a.m., 10:10 a.m., 10:30 a.m., 11:00 a.m., 11:50 a.m. and at noon.  On 3/6/14 between 9:15 a.m. and 10:30 a.m. 3 random residents (who wished to remain anonymous) stated they had noticed an odor on the 400 hall. One of the random residents stated her room smelled sometimes but staff would "put things up [air freshner items]" and the smell		<b>FACILITY SYSTEMS</b> On or before 3/18/2014 staff have been reeducated by the RN, Nurse Practice Educator, or designee, on the requirement to identify and correct the root cause of all persistent odors in the facility, or to report to management any uncorrectable odors. On 3/11/14 and again 3/25/14 Resident Council meeting discussed odors and indicated that they were unaware of any odor problems in the center, but were aware to report any persistent unpleasant	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2014  
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 03/06/2014
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 252	Continued From page 2 would go away. A different resident stated when he/she went to an activity on the 400 hall they had noticed the smell.  On 3/6/14 at 11:50 a.m. CNA #1 stated she could smell the urine in Resident #1's bathroom. The CNA stated the laundry was washed by the resident's family member and placed in the laundry basket until the family picks it up. The CNA stated the resident's urostomy leaked.  At noon the DON stated the hall did smell when the urostomy was changed. At that time the surveyor showed the DON the laundry basket in the bathroom. The DON stated the bathroom smelled of urine.  On 3/6/14 at 3:55 p.m. the EUM stated the resident's urostomy had leaked on 3/5/14 but had not leaked "today."	F 252	odors to facility staff.  <b>MONITORS</b> Beginning the week of 3/17/2014 facility Department Managers will perform round audits of resident rooms and common areas to identify unaddressed persistent odors. These audits will occur 5 x a week for 4 weeks then monthly x 2 months. Any persistent odors identified will be immediately addressed. The results of these audits will be reviewed in the Customer Excellence Committee of the facility's Quality Assurance and Performance Improvement (QAPI) Committee monthly, for three months, with Plans of correction adopted and modified as appropriate. The Customer Excellence Team Leader will ensure compliance.  <b>Date of Compliance: March 18, 2014</b>		
	On 3/6/14 at 4:00 p.m. the Administrator, Social Worker, and the DON were informed of the above concern. The Administrator stated the facility would start immediately to correct the concern.				

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/06/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD</b> <b>BOISE, ID 83704</b>
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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) COMPLETE DATE
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiency was cited during a complaint survey for your facility.</p> <p>The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Sherri Case, LSW, QMRP</p>	C 000		
C 361	<p><b>02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT</b></p> <p>07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner.</p> <p>This Rule is not met as evidenced by: Please refer to F 252 as it relates to odors.</p>	C 361	<p>Please Refer to F 252</p>	<p>RECEIVED MAR 26 2014 FACILITY STANDARDS</p>

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>JBRdc</i>	TITLE  <i>Administratoe</i>	(X6) DATE  <i>32414</i>
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IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

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

April 14, 2014

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

Provider #: 135079

Dear Mr. Rudd:

On **March 6, 2014**, a Complaint Investigation survey was conducted at Apex Center. Linda Kelly, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation.

The following documentation was reviewed:

- The facility's clinical record for the identified resident;
- Emergency department records dated May 20, 2013, for the identified resident;
- Facility Event Reports from May 2013 through February 2014 that included an Event Report for the identified resident;
- Facility "Reportable" Event Investigations for May 2013 through February 2014 that included a "Reportable" Investigation for the identified resident; and,
- Facility clinical records for two other residents.

Interviews were conducted with the following:

- The Administrator;
- The Director of Nursing Service (DNS);
- Four interviewable residents;
- Five Certified Nursing Assistants (CNAs); and,
- Three licensed nurses (LNs).

The complaint allegations, findings and conclusions are as follows:

Joseph B. Rudd, Administrator  
April 14, 2014  
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### **Complaint #ID00006055**

#### ALLEGATION #1:

The complainant stated the identified resident was admitted to the facility for respite care, and the facility would not give Advil PM and a Benadryl at bedtime, per the resident's usual, because they did not have a doctor's order.

#### FINDINGS:

Review of the identified resident's clinical record revealed hospice care was in place at the time the resident was admitted to the facility and that the hospice's physician discontinued the resident's Advil PM and Benadryl the day the resident was admitted to the facility.

During an interview, the DNS stated the use of Advil PM and Benadryl was discussed with the resident's hospice nurse on the day the resident was admitted to the facility, and the hospice's nurse discussed it with the hospice's physician who discontinued the two medications.

Interdisciplinary Progress Notes (IPNs) contained documentation that the resident was confused about being in the facility throughout the five-day respite stay, and the resident "wandered around the unit" at times. The IPNs documented the resident slept well the first night and was "somewhat distressed" and wanted to go home the next day but "calmed down" with reassurance and redirection. During the third night, the resident was up at 2:00 a.m. then back to bed then used a walker and stand by assistance to walk to the common area by the nurses' station. By night four, the resident stood up from the wheelchair and got out of bed without assistance, then "became upset and started yelling" when staff stopped the resident from undressing in a public area. The resident was discharged before noon the next day.

No deficient practice was identified because the resident's clinical record contained documentation that showed the facility provided timely and appropriate interventions.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The complainant stated the identified resident was admitted to the facility May 16, 2013, and discharged sometime before noon on May 20, 2013, as planned. The complainant stated the discharging nurse asked if the resident had "sundowners" and that the resident had caused injury to a nurse by pushing the nurse down. The complainant stated the resident was slightly confused

but very sweet and kind and could not have done that because the resident weighed less than 100 pounds. The complainant stated at about 2:00 p.m. several bruises on the resident's hands and arms, including a bruise from the joint of the middle finger on the right hand to the wrist, and both ankles were noticed when a hospice's aide arrived to assist to care for the resident. The complainant stated the resident's hand and wrist were also sore. The complainant stated the resident was evaluated in an emergency room (ER) at approximately 4:00 p.m. on May 20, 2013, and diagnosed with a dislocated middle finger.

#### FINDINGS:

The identified resident's clinical record contained a May 19, 2013, Interdisciplinary Progress Note (IPN) that documented the resident received a skin tear to the right middle finger while en route to the bathroom. An Event Report dated May 19, 2013, at 12:20 a.m. documented the same.

The May 19, 2013, Event Report also documented the resident "was putting on (resident's) shoes and beginning to get out of bed" and "pushing (the resident's) transport chair" when a licensed nurse arrived and assisted the resident to the bathroom. The report contained documentation that the resident "didn't want to use (the) walker," sat on the transport chair and "pushed (self) swiftly toward the (bathroom) door." It documented the resident's right middle finger hit the doorjamb as the resident went into the doorway that resulted in a one half inch skin tear on the knuckle. Bleeding was stopped when pressure was applied, then an antibiotic ointment and a Band-Aid was applied. Physiological risk factors included fragile skin and aspirin use. No active skin conditions were identified, and the last skin assessment was May 17, 2013. The resident's care plan was updated to include "Encourage resident to allow staff to navigate (resident) into bathroom." Mobility and the resident's cognition were noted as "Contributing Factors" along with the comment, "Resident normally does not use a wheelchair at home."

A Root Cause Analysis Worksheet regarding the May 19, 2013, event documented the resident had to use the bathroom, was in a hurry, self-propelled to the bathroom and hit hand on doorjamb. It documented, "(A) sm(all) skin tear was seen on the (right) middle finger. It was bleeding; however, the bleeding ceased (with) applied pressure (after) a couple minutes."

An Interdisciplinary Progress Note by a licensed nurse (LN) dated May 20, 2013, at 12:50 p.m. documented "Resident (discharged) home ...with walker, w/c (wheelchair) and all belongings. Skin (check) done and no new skin issues noted..." Another May 20, 2013, IPN by a LN timed at 7:25 p.m., documented "...This nurse assisted resident to bathroom early today no bruising noted to BLE (bilateral lower extremities) bruise to right hand noted. Skin intact..."

The identified resident's emergency department records dated May 20, 2013, at 4:50 p.m.

included a musculoskeletal system physical examination; "Bruising noted proximal to bilateral ankles. Two smaller bruises noted on dorsum of left wrist--one is old per family. Bruising noted to right hand with swelling/boutonniere deformity of middle finger. No other bony deformity/tenderness noted." Documentation of a Reexamination/Reevaluation by the emergency physician on May 20, 2013, included "(5:06 p.m.) Notes: Staff has contacted (facility) for records. They stated pt (patient) became violent while being transferred to a commade (sic) and pt (patient) struck her hand against wall." "(5:33 p.m.) Entry at 06:20 on 5/19 documents skin tear to right middle finger while en route to bathroom. No other incidents noted in record. Will request med(ication) record." "(5:59 p.m.) ...Documentation does not mention agitation or need for restraints which is suggested by bruising. Although (sic) not documentation, pt could have agitation related to dementia/sundowning..." "(6:08 p.m.) Notes: Hand xray is negative for fracture/dislocation. Will consult with oncall hand surgery." "(6:28 p.m.) Consulted with (physician's name) for finger injury. He will see pt in office. Benefit of treatment may be outweighed by risks of treatment (extension splint)..."

The DNS, two LNs and two CNAs were interviewed. All of the nurses and a CNA remembered the skin tear on the resident's right middle finger. The other CNA did not recall the resident. None of the staff recalled any other skin issues for the resident.

Four interviewable residents were interviewed. All four residents said they knew how and when to report abuse. Two of the residents stated some of the staff was rude but they, the residents, had not reported the rudeness. The other two residents said they had not experienced or witnessed any problems.

The DNS stated she was invited to assess the resident on May 22, 2013, at which time she noted purple bruising to dorsal side of the resident's right hand from the base of the nail to the last knuckle with a skin tear/scab to the second knuckle, bruising at the base of the ring and index fingers and bruising to the inner palm of the hand; two purple bruises surrounded in reddish hue on the left wrist, purple/red bruising discoloration above the right outer ankle and purple/red bruising discoloration at the left inner and outer ankle. The DNS stated that while in the facility, the resident was observed several times to self-propel the wheelchair with the foot pedals down and to attempt to step over the foot pedals. The DNS provided documentation of the dates of the observations and the staff who observed them.

A Summary of Investigation by the DNS, Licensed Social Worker and a Unit Manager dated May 21, 2013, documented "Conclusion: Facility unable to substantiate that injury occurred while in facility through interviews of staff and that injuries were not noted until three hours after discharge from facility."

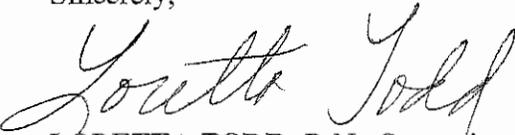
Joseph B. Rudd, Administrator  
April 14, 2014  
Page 5 of 5

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

  
LORETTA TODD, R.N., Supervisor  
Long Term Care

LT/dmj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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FILE COPY

March 31, 2014

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

Provider #: 135079

Dear Mr. Rudd:

On **March 6, 2014**, a Complaint Investigation survey was conducted at Apex Center. Linda Kelly, R.N. and Sherri Case, L.S.W., Q.M.R.P. conducted the complaint investigation. This complaint was investigated with a second complaint on March 5 and 6, 2014.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00006239**

ALLEGATION #1:

The complainant stated there was a "stench of urine" on one of the hallways.

FINDINGS:

Based on observations, records reviewed and staff and residents' interviews, it was determined that the facility failed to ensure a clean and comfortable environment that was free of odors. The facility was cited at F252 as it relates to resident environment.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the

Joseph B. Rudd, Administrator

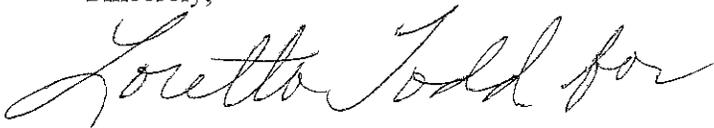
March 31, 2014

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Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. 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 cursive script that reads "Lorene Kayser for".

LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor  
Long Term Care

LKK/dmj