



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 3875

November 19, 2013

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 **November 12, 2013**, a Facility Fire Safety and Construction survey was conducted at **Apex Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 2, 2013**. Failure to submit an acceptable PoC by **December 2, 2013**, may result in the imposition of civil monetary penalties by **December 22, 2013**.

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 **December 17, 2013**, (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 **December 17, 2013**. A change in the seriousness of the deficiencies on **December 17, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 17, 2013**, includes the following:

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Denial of payment for new admissions effective **February 12, 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 **May 12, 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 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 **November 12, 2013**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

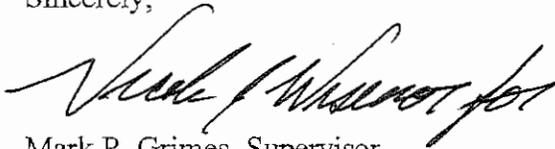
BFS Letters (06/30/11)

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

This request must be received by **December 2, 2013**. If your request for informal dispute resolution is received after **December 2, 2013**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 11/18/2013
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 11/12/2013
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 000	<p>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 beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on November 12, 2013. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><i>This Plan of Correction is submitted as required by law. By submitting this Plan of Correction, Genesis Health Care Apex Center does not admit that the deficiencies cited in the CMS form 2567L exist, nor does the Center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. This Center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</i></p> <p style="text-align: center;">RECEIVED DEC - 2 2013 FACILITY STANDARDS</p>	
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p>	K 025	<p>K025 RESIDENT SPECIFIC</p> <p>The smoke barriers identified during the survey in the West TV Room Telephone Closet, the 500 hall corridor ceiling tile, and the east data room by room 415 have all been repaired, on or before December 2, 2013; thus providing protection to all residents in these areas.</p>	

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

TITLE

(X6) DATE

[Handwritten Signature]

Administrative

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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 025	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke resistive properties of a smoke barrier ceiling and wall. Openings in smoke barriers can allow smoke and fire gasses to enter other smoke compartments in the event of a fire. The deficient practice affected three of twelve smoke compartments, staff, and 28 residents. The facility has the capacity for 148 beds with a census of 87 the day of survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 11/12/13 at 1:32 p.m., revealed four one half inch unsealed circular penetration around cable that passed through the west TV room telephone closet smoke barrier ceiling. Interview with the facility maintenance engineer revealed that the facility was not aware of the unsealed penetration in the smoke barrier ceiling. 2. Observation on 11/12/13 at 2:11 p.m., revealed a three inch unsealed penetration where the corner of a 2' x 4' ceiling tile was missing in the 500 hall corridor smoke barrier ceiling. Interview with the facility maintenance engineer revealed that the facility was not aware of the unsealed penetration in the smoke barrier ceiling. 3. Observation on 11/12/13 at 2:45 p.m., revealed a one half inch unsealed penetration around a bundle of data wires that ran through wall in the east data room by room 415. Interview with the facility maintenance engineer revealed that the facility was not aware of the unsealed penetration in the smoke barrier wall. <p>Actual NFPA Standard: NFPA 101, 8.3.6.1 (1) a. and b. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic</p>	K 025	<p>OTHER RESIDENTS All other areas of the facility have been observed by the facility Maintenance Supervisor, on or before December 2, 2013, with repairs made as needed; thus providing protection to any center residents not identified in the survey.</p> <p>FACILITY SYSTEMS Effective December 1, 2013 all contractors will be informed of the new center standard that they must provide photographic evidence consisting of before work and after work shots of all areas where penetrations are made in a smoke barrier and which show the smoke barrier sealed upon completion of their work.</p> <p>MONITORS Beginning December 2013 for three months, the Maintenance Supervisor will provide to the Safety Excellence Committee of the Facility's Quality Assurance and Performance Improvement (QAPI) Program, a log of contractor labor encounters for the preceding thirty-days affecting smoke barriers with associated before and after photos demonstrating that the smoke barriers remain intact following completion of the contractor labor.</p>	

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K 025	Continued From page 2 tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected by filling the space between the penetrating item and the smoke barrier with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide complete coverage by the automatic sprinkler system as required for a Type V (111) protected, ordinary construction. The lack of complete automatic sprinkler protection can allow an incipient fire to grow and spread. The deficient practice affected one of twelve smoke compartments, staff, and no residents. The facility has the capacity for 148 beds with a census of 87 the day of survey. Findings include:	K 056	K056 RESIDENT SPECIFIC The overhang outside the 300 hall northeast exit will have installed a fire sprinkler on or before December 30, 2013 (pending manufacture and delivery of the necessary parts) thus protecting all residents that receive service in that portion of the center. We are hereby requesting a variance to the December 17, 2013 compliance date identified in the cover letter accompanying this 2567L. OTHER RESIDENTS All other exit overhangs of the facility have been observed by the facility Maintenance Supervisor, on or before December 2, 2013, with no repairs needed; thus providing protection to any center residents not identified in the survey. FACILITY SYSTEMS On or before December 30, 2013 the new sprinkler head will be incorporated into the facility's fire sprinkler system and which is evaluated quarterly, by a qualified outside contractor, for functionality.	

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K 056	Continued From page 3 Observation on 11/12/13 at 1:00 p.m. revealed that sprinkler coverage was not provided for the attached combustible overhang outside the 300 hall northeast exit. The overhang was approximately eight feet by sixteen feet in dimension. Interview with the Maintenance Supervisor on 11/12/13 at 1:00 p.m. revealed that the facility was not aware that the attached combustible overhang was unsprinklered. Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 13, 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft. (1.2 m) in width. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.	K 056	MONITORS Beginning December 2013 for three months, the Maintenance Supervisor will provide to the Safety Excellence Committee of the Facility's Quality Assurance and Performance Improvement (QAPI) Program, with copies of any new reports from the fire sprinkler contractor regarding the functionality of this new sprinkler head specifically or the fire sprinkler system in general.		

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C 000	<p>16.03.02 INITIAL COMMENTS</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 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 beds.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on November 12, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>			C 000	<p>RECEIVED</p> <p>DEC - 2 2013</p> <p>FACILITY STANDARDS</p>		
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This RULE: is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p> <p>1. K025 Penetrations.</p>			C 226			Please See K025

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

Tom Mroz

Administrator

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C 226	Continued From Page 1 2. K056 Fire Sprinkler.	C 226	Please See K056	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.