



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – 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

January 26, 2018

Sherrie Nunez, Administrator
Apex Center
8211 Ustick Road
Boise, ID 83704-5756

Provider #: 135079

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Nunez:

On **January 18, 2018**, 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. 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** completion date for each federal and state tag in column (X5) Completion Date to signify when

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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 **February 8, 2018**. Failure to submit an acceptable PoC by **February 8, 2018**, may result in the imposition of civil monetary penalties by **February 28, 2018**.

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. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 22, 2018**, (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 **February 22, 2018**. A change in the seriousness of the deficiencies on **February 22, 2018**, 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 **February 22, 2018**, includes the following:

Denial of payment for new admissions effective **April 18, 2018**.
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 **July 18, 2018**, 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 Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **January 18, 2018**, 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:

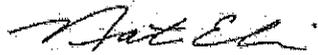
BFS Letters (06/30/11)

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

This request must be received by **February 8, 2018**. If your request for informal dispute resolution is received after **February 8, 2018**, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

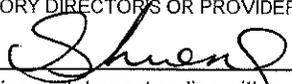
Printed: 01/25/2018
FORM APPROVED
OMB NO. 0938-0391

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 01/18/2018
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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	<p>INITIAL COMMENTS</p> <p>The facility consists of two Type V (111) buildings that are separated by a connecting corridor with 2-hour separation. 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 currently licensed for 148 SNF/NF beds and had a census of 72 during the time of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 16 to January 18, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">FEB - 8 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p> <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>	
K 161 SS=D	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p style="text-align: center;">Construction Type</p> <p>1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p>	K 161	<p>K 161</p> <p><u>Corrective Actions</u></p> <p>The Maintenance Director corrected; the three unsealed approximately two-inch diameter holes in the wall at the ceiling line on east side of the movie room was corrected, and the two unsealed approximately two-inch diameter holes in the ceiling on the</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 2/7/18.
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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 161	Continued From page 1 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations in rated construction assemblies has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces. This deficient practice affected 17 residents in 1 of 6 smoke compartments, staff and visitors on the date of the survey. Findings include:	K 161	west side of the movie room on 1/21/18. <u>Other residents affected</u> All residents have the potential to be affected. <u>Facility Systems</u> An inspection was completed by the Maintenance Director on 1/23/18 to validate no unsealed penetrations throughout the facility were identified. The Center Executive Director and/or designee provided education on 2/1/18 to the maintenance staff and related to the requirement of maintaining the facilities fire and smoke resistive properties by ensuring penetrations are sealed according to the NFPA recommendations. <u>Monitoring</u> Beginning the week of 2/22/18, The Maintenance Director and/or designee will conduct random audits of the facility weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met. Any findings and or revisions needed will be brought through the facilities	

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K 161	<p>Continued From page 2</p> <p>During the facility tour conducted on January 17, 2018 from approximately 10:30 AM to 1:30 PM, the following unsealed penetrations in the one-hour construction were revealed:</p> <p>1) Three (3) unsealed approximately two-inch diameter holes in the wall at the ceiling line on the east side of the movie room.</p> <p>2) Two (2) unsealed approximately two-inch diameter holes in the ceiling on the west side of the movie room.</p> <p>When asked about the unsealed penetrations, the Maintenance Director stated the facility was installing cabling and the project was not yet completed.</p> <p>Actual NFPA standard:</p> <p>19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</p> <p>8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.</p> <p>8.2.2.2 Fire compartments shall be formed with fire barriers that comply with Section 8.3.</p> <p>8.3.5.6 Membrane Penetrations. 8.3.5.6.1 Membrane penetrations for cables,</p>	K 161	<p>QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance.</p> <p><u>Date of Compliance</u></p> <p>2/22/18</p> <p>K 325</p> <p><u>Corrective Actions</u> The facilities housekeeping director completed a test on all the manual and automatically activated ABHRs throughout the facility to ensure proper operation and functioning on 2/7/18 The Maintenance Director relocated the ABHRs away from the ignition source in rooms; 603, 605 and the west wing staff breakroom on 1/21/18.</p> <p><u>Other residents affected</u> All residents have the potential to be affected.</p> <p><u>Facility Systems</u></p>	

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K 161	Continued From page 3 cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device and shall comply with 8.3.5.1 through 8.3.5.5.2.	K 161	An inspection was completed by the Maintenance Director on 1/23/18 to validate no other ABHR dispensers were installed or abutting an ignition source throughout the facility. The Center Executive Director and/or designee provided education on 2/1/18 to the housekeeping staff and maintenance staff related to the requirement of installing, testing and documentation of the operation of the ABHRs. <u>Monitoring</u> Beginning the week of 2/22/18, The Maintenance Director and/or designee will conduct random audits of the facility weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance. <u>Date of Compliance</u> 2/22/18	
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on record review, observation and	K 325		

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K 325	<p>Continued From page 4</p> <p>interview, the facility failed to ensure automatically and manually operated Alcohol Based Hand Rub Dispensers (ABHR), were maintained in accordance with NFPA 101. Failure to install, test and document operation of ABHR dispensers under manufacturer's recommendations in accordance with the standard has the potential of increasing the risk of fires from flammable liquids. This deficient practice affected 72 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on 1/16/18 from 4:00 PM to 4:30 PM and 1/17/18 from 1:30 - 3:45 PM, observation of installed ABHR dispensers revealed a mix of automatic and manually activated dispensers had been installed in six of six smoke compartments. Interview of Housekeeping staff in the Housekeeping storage area on 1/17/18 established she did not document any testing when refilling dispensers and was not aware of this requirement.</p> <p>2) Subsequent review of provided facility inspection records did not demonstrate documentation of any actions performed for inspection and testing per manufacturer's recommendations, or the requirements of the standard having been performed, only a check mark in a column marked: "Functionality tested".</p> <p>3) During the facility tour on 1/17/18 from 1:30 PM to 3:45 PM revealed the following location with ABHR dispensers installed or abutting an ignition source:</p> <p>Resident rooms 603 and 605 both had an ABHR dispenser installed over a light switch.</p>	K 325	<p>K 353</p> <p><u>Corrective Actions</u></p> <p>The facilities maintenance director inspected and documented the facilities dry system gauges to ensure proper operation and functioning on 1/21/18.</p> <p>The Maintenance Director will inspect and document weekly inspections of the dry system gauges. Post indicator valve located on the southwest side of the facility to ensure both sight glass inspection windows to ensure verification of it being open or closed is easily readable on 1/22/18.</p> <p><u>Other residents affected</u></p> <p>All residents have the potential to be affected.</p> <p><u>Facility Systems</u></p> <p>An inspection was completed February 7, 2018 by the Maintenance Director to validate the site glass is readable</p> <p>The Center Executive Director and/or designee provided education on 2/1/18 to maintenance staff related to the requirement of the control valves inspections, to include the verification</p>	

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K 325	<p>Continued From page 5</p> <p>Staff Breakroom in the West wing had an ABHR dispenser installed within 1/2 inch of a light switch.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke</p>	K 325	<p>of the visual ability to read if the valve is in the open or closed position.</p> <p>Monitoring Beginning the week of 2/22/18, The Maintenance Director and/or designee will conduct random audits of the post indicator valve(s) weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance.</p> <p>Date of Compliance 2/22/18</p> <p>K 511</p> <p>Corrective Actions The portable air conditioning unit and portable heater noted in the recreation office were unplugged from the RPT on 1/17/18. The portable heating unit was inspected by the maintenance</p>

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K 325	<p>Continued From page 6</p> <p>compartment, except as otherwise provided in 19.3.2.6(6).</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p>	K 325	<p>director to ensure the device did not exceed 212 degrees Fahrenheit per the NFPA 101.</p> <p>The portable heater noted in the business office was unplugged from the RPT 1/17/18, and inspected by the maintenance director to ensure the device did not exceed 212 degrees Fahrenheit per the NFPA 101.</p> <p><u>Other residents affected</u> All residents have the potential to be affected.</p> <p><u>Facility Systems</u> An inspection was completed by the Maintenance Director to validate the use of RPTs were in accordance with NFPA 70 throughout the facility on 1/22/18 The Center Executive Director and/or designee provided education on 2/1/18 to the IDT and maintenance staff related to the requirement of the use of RPTs, and portable heating units.</p> <p><u>Monitoring</u> Beginning the week of 2/22/18,</p>

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K 353	<p>Continued From page 8</p> <p>Findings include:</p> <p>1) During review of provided facility inspection and testing records conducted on 1/16/18 from 9:30 AM to 1:00 PM, no records were available indicating a weekly inspection of dry system gauges had been conducted. Interview of the Maintenance Director revealed he had not documented any weekly inspections of the dry system gauges and was not aware of this requirement.</p> <p>2) During the facility tour conducted on 1/17/18 from 1:00 PM to 3:30 PM, observation of the Post Indicator Valve located on the southwest side of the facility revealed that both sight glass inspection windows were clouded, making verification if the valve was in the open or closed position impossible.</p> <p>Actual NFPA standard:</p> <p>13.3 Control Valves in Water-Based Fire Protection Systems.</p> <p>13.3.2 Inspection.</p> <p>13.3.2.1 All valves shall be inspected weekly.</p> <p>13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p> <p>13.3.2.2* The valve inspection shall verify that the valves are in the following condition:</p> <p>(1) In the normal open or closed position (2)*Sealed, locked, or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks</p>	K 353	<p>The portable heater noted in the business office was unplugged from the RPT 1/17/18 and inspected by the maintenance director to ensure the device did not exceed 212 degrees Fahrenheit per the NFPA 101.</p> <p><u>Other residents affected</u> All residents have the potential to be affected.</p> <p><u>Facility Systems</u> An inspection was completed by the Maintenance Director to validate the use of RPTs were in accordance with NFPA 70 throughout the facility on 1/22/18. The Center Executive Director and/or designee provided education on 2/1/18 to the IDT and maintenance staff related to the requirement of the use of RPTs, and portable heating units.</p> <p><u>Monitoring</u> Beginning the week of 2/22/18, The Maintenance Director and/or designee will conduct random audits of the facility weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met.</p>

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 01/18/2018
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K 511	<p>Continued From page 10 observation of the Recreation office, revealed a portable air conditioning unit and a portable heater plugged into a RPT.</p> <p>2) During the facility tour conducted on 1/17/18 from approximately 1:30 PM to 3:30 PM, observation of the Business office in the East wing, revealed a portable heater plugged into a RPT.</p> <p>Actual NFPA standard: NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment</p>	K 511	<p>oxygen storage room on the East side segregated the empty cylinders from the full on 1/29/18.</p> <p>The Center Executive Director and/or designee provided education on 2/1/18 to the housekeeping staff and maintenance staff related to the requirement of segregation of empty versus full oxygen cylinders.</p> <p><u>Monitoring</u> Beginning the week of 2/22/18, The Maintenance Director and/or designee will conduct random audits of the facility weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance.</p> <p><u>Date of Compliance</u> 2/22/18</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 511	Continued From page 11 may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service (6) Arcing effects (7) Classification by type, size, voltage, current capacity, and specific use (8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment (B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. Reference UL 1363 XBYS.GuidelInfo Relocatable Power Taps	K 511		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to prohibit the use of portable heating devices in accordance with NFPA 101. Portable heaters have been historically linked to facility fires. This deficient	K 781		

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K 781	Continued From page 12 practice had the potential to affect 11 residents in 1 of 6 smoke compartments, staff and visitors on the date of the survey. Findings include: 1) During the facility tour conducted on 1/17/18 from approximately 1:30 PM to 3:30 PM, observation of the Recreation office, revealed a portable heater in use that was plugged into a RPT. 2) During the facility tour conducted on 1/17/18 from approximately 1:30 PM to 3:30 PM, observation of the Business office in the East wing, revealed a portable heater in use that was plugged into a RPT. Interview of the Maintenance Director revealed no documented testing of the upper temperature limit of the heaters was being performed and he was not aware of the requirement prohibiting space heaters. Actual NFPA standard: 19.7.8 Portable Space-Heating Devices. Portable spaceheating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C).	K 781		
K 923 SS=D	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K 923		

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K 923	<p>Continued From page 13</p> <p>>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full has the potential of using incorrect cylinders during an emergency requiring supplemental oxygen. This deficient practice affected 18 residents in 1 of 6 smoke</p>	K 923		

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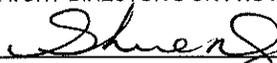
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K 923	<p>Continued From page 14 compartments, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 1/16/18 from approximately 4:00 PM to 4:15 PM, observation of the oxygen storage area in the 500 wing of the facility, revealed approximately thirteen (13) "E" size oxygen cylinders in stand-up crash carts. Further observation of this area revealed no signs or indications as to whether the stored cylinders were empty or full. When asked how staff identifies full from empty oxygen cylinders, the Maintenance Director stated there was no clear way to differentiate the cylinders between empty or full.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>11.6.5 Special Precautions - Storage of Cylinders and Containers.</p> <p>11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier.</p> <p>11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders.</p> <p>11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.</p>	K 923		

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E 000	<p>Initial Comments</p> <p>The facility consists of two Type V (111) buildings that are separated by a connecting corridor with 2-hour separation. 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 located in a municipal fire district with city and county support services. The facility is currently licensed for 148 SNF/NF beds and had a census of 72 during the time of the survey.</p> <p>The following deficiencies were cited during the Emergency Preparedness survey conducted on January 16 to January 18, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction</p>	E 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">FEB - 8 2018</p> <p style="text-align: center;">FACILITY STANDARDS</p> <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>	
E 015 SS=C	<p>Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)</p> <p>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:</p>	E 015	<p>E 015</p> <p>Corrective Actions</p> <p>On 1/31/18 the facility IDT reviewed the Emergency Preparedness plan to include the facilities policy and procedure related to the subsistence needs for staff and patients. The Policy and Procedure was updated to include the services provided by the contracted vendor for the removal of</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEI	(X6) DATE 2/7/18
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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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E 015	<p>Continued From page 1</p> <p>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(i) Food, water, medical and pharmaceutical supplies</p> <p>(ii) Alternate sources of energy to maintain the following:</p> <p>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(B) Emergency lighting.</p> <p>(C) Fire detection, extinguishing, and alarm systems.</p> <p>(D) Sewage and waste disposal.</p> <p>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.</p> <p>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:</p> <p>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:</p> <p>(A) Food, water, medical, and pharmaceutical supplies.</p> <p>(B) Alternate sources of energy to maintain the following:</p> <p>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.</p> <p>(2) Emergency lighting.</p> <p>(3) Fire detection, extinguishing, and alarm systems.</p> <p>(C) Sewage and waste disposal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, it was determined the facility failed to develop and maintain an</p>	E 015	<p>sewage and waste in the event of a disaster.</p> <p>Other residents affected All residents have the potential to be affected.</p> <p>Facility Systems The facility IDT was re- educated on 1/31/18 by the Center Executive Director of the Emergency Preparedness Plan policy and procedure for the provision of subsistence needs for staff and patients to ensure the facilities ability to provide continuing care and services for the residents during an emergency.</p> <p>Center staff was re-educated by PDS on or before 2/22/18 regarding the Emergency Preparedness Plan policy and procedure for the provision of subsistence needs for staff and patients to ensure the facilities ability to provide continuing care and services for the residents during an emergency.</p> <p>IDT will add the facility Emergency Preparedness plan to be reviewed/ audited by different department personnel quarterly to ensure compliance with Federal, State and</p>

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E 015	<p>Continued From page 2</p> <p>emergency plan, policies and procedures, which provides subsistence needs of residents and staff should they need to evacuate or shelter in place during a disaster. Lack of subsistence policies limits the facility's ability to provide continuing care and services for residents during an emergency. This deficient practice affected 72 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/16/18 from 9:30 AM to 5:00 PM, review of provided policies and procedures for the facility did not indicate the ability of the facility to provide sewage and waste disposal for residents and staff in the event of evacuation or while sheltering in place during a disaster.</p> <p>On page 14 of the emergency plan, contact information was provided for vendors, however the plan did not indicate what, if any services would be provided during disasters for removal of sewage and waste by these vendors.</p> <p>Reference: 42 CFR 483.73 (b) (1)</p>	E 015	<p>local laws and any findings and or revisions needed will be brought through the facilities QAPI meeting.</p> <p>Monitoring Beginning the week of 2/22/18, The Center Executive Director will designate an IDT member to review/ audit the facility Emergency Preparedness plan to ensure compliance with Federal, State and local laws weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met for the facilities policy and procedure of Subsistence needs for staff and residents. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance.</p>
E 031 SS=C	<p>Emergency Officials Contact Information</p> <p>CFR(s): 483.73(c)(2)</p> <p>[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:</p> <p>(2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff.</p>	E 031	<p>Date of Compliance</p> <p>2/22/18</p> <p>E 031</p>

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E 031	<p>Continued From page 3</p> <p>(ii) Other sources of assistance.</p> <p>*[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance.</p> <p>*[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure current contact information for emergency management officials and other resources of assistance was provided in the emergency communication plan. Failure to provide updated information for resources available to the facility has the potential to hinder facility response and continuity of care for the 72 residents in the facility on the date of the survey.</p> <p>Findings include:</p> <p>On 1/16/18 from 9:30 AM - 5:00 PM, review of the emergency plan, policies and procedures, revealed the plan did not include the number for the State Licensing and Certification Agency in the listed contacts for emergency officials.</p> <p>Reference: 42 CFR 483.73 (c) (2)</p>	E 031	<p><u>Corrective Actions</u> On 1/31/18 the facility IDT reviewed the Emergency Preparedness plan to include the facilities policy and procedure related to the Emergency Officials Contact Information. The Policy and Procedure was updated to include the number of the State Licensing and Certification Agency in the listed contacts for emergency officials.</p> <p><u>Other residents affected</u> All residents have the potential to be affected.</p> <p><u>Facility Systems</u> The facility IDT was re- educated on 1/31/18 by the Center Executive Director of the Emergency Preparedness Plan, policy and procedure to ensure current contact information for emergency management officials, and other resources of assistance to include the number of the State Licensing and Certification Agency in the listed contacts for emergency officials.</p> <p>Center staff was re-educated by PDS on or before 2/22/18 on the facilities Emergency Preparedness Plan, policy</p>

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<p>E 036 E 036 SS=F</p>	<p>Continued From page 4 EP Training and Testing CFR(s): 483.73(d)</p> <p>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually.</p>	<p>E 036 E 036</p>	<p>and procedure for Emergency Officials Contact Information, to include the addition of the number of the State Licensing and Certification Agency in the listed contacts for emergency officials.</p> <p>IDT will add the facility Emergency Preparedness plan to be reviewed/ audited by different department personnel quarterly to ensure compliance with Federal, State and local laws related to facilities communication plan. Any findings and or revisions needed will be brought through the facilities QAPI meeting Quarterly.</p> <p>Monitoring Beginning the week of 2/22/18, The Center Executive Director will designate an IDT member to review/ audit the facility Emergency Preparedness plan to ensure compliance with Federal, State and local laws weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met for the facilities policy and procedure related to the communications plan, and ensuring the Emergency Officials contact information is current and accurate.</p>	
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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 01/18/2018
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)
E 036	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide a emergency prep training and testing program. Lack of a facility emergency training and testing program covering the emergency preparedness plan, policies and procedures, has the potential to hinder staff response during a disaster. This deficient practice affected 72 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/16/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policies and procedures, found no documentation demonstrating the facility had a current training and testing program for staff based on the plan.</p> <p>Interview of 3 of 3 staff conducted on 1/16/18 from 2:30 PM to 4:15 PM and 2 of 2 staff conducted on 1/17/18 from 8:45 AM to 9:45 AM, established staff had not participated in any specific training and testing program on the emergency plan contents, only the location of the emergency box.</p> <p>Further examination of orientation documents provided revealed a section of "Day Two" was labeled: "HazCom, Emergency Plan". Interview of RN 2 on 1/16/18 from 3:35 PM to 4:15 PM, established she was taught where to find the plan, but no training on the contents of the plan.</p> <p>Reference: 42 CFR 483.73 (d)</p>	E 036	<p>Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months.</p> <p>Center Executive Director will be responsible for compliance.</p> <p><u>Date of Compliance</u></p> <p>2/22/18</p> <p>E 036</p> <p><u>Corrective Actions</u> On 2/7/18 the Center Executive Director, Maintenance Director and Human Resource designee reviewed and updated the EPP training and testing program, to ensure it covered the facility Emergency preparedness plan policies and procedures. The IDT developed an ongoing calendar of scheduled disaster preparedness that include trainings for the current year, that will be reviewed an updated upon the annual EPP review, and as needed by the IDT.</p> <p><u>Other residents affected</u></p>
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1)	E 037	

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E 037	<p>Continued From page 6</p> <p>(1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least annually.</p> <p>(iv) Periodically review and rehearse its</p>	E 037	<p>All residents have the potential to be affected.</p> <p>Facility Systems</p> <p>The facility IDT was re- educated on or before 2/22/18 by the Center Executive Director of the Emergency Preparedness training and testing plan developed to include the planned trainings for the current year.</p> <p>Center staff was re-educated by PDS on or before 2/22/18 on the facilities Emergency Preparedness training and contents of the plan developed to include the planned trainings for the current year.</p> <p>IDT will add the facility Emergency Preparedness plan to be reviewed/ audited by different department personnel quarterly to ensure compliance with Federal, State and local laws related to facilities training and testing plan. Any findings and or revisions needed will be brought through the facilities QAPI meeting Quarterly.</p>	

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E 037	<p>Continued From page 7</p> <p>emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services</p>	E 037	<p><u>Monitoring</u> Beginning the week of 2/22/18, The Center Executive Director will designate an IDT member to review/audit the facility Emergency Preparedness plan to ensure compliance with Federal, State and local laws weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met for the facilities policy and procedure related to the facilities training and testing plan. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance.</p> <p><u>Date of Compliance</u> 2/22/18</p> <p>E 037</p> <p><u>Corrective Actions</u></p>	

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E 037	<p>Continued From page 8 under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency</p>	E 037	<p>On 2/7/18 the Center Executive Director, Maintenance Director and Human Resource designee reviewed and updated the EPP training and testing program, to ensure it covered the facility Emergency preparedness plan policies and procedures. The IDT developed an ongoing calendar of scheduled disaster preparedness that include trainings for the current year, that will be reviewed an updated upon the annual EPP review, and as needed by the IDT.</p> <p><u>Other residents affected</u> All residents have to potential to be affected.</p> <p><u>Facility Systems</u> The facility IDT was re- educated on or before 2/22/18 by the Center Executive Director of the Emergency Preparedness training and testing plan developed to include the planned trainings for the current year.</p> <p>Center staff was re-educated by PDS on or before 2/22/18 on the facilities Emergency Preparedness training and contents of the plan developed to include the planned trainings for the current year.</p>

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/18/2018
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E 037	Continued From page 9 procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide an emergency prep training program. Lack of a training program on the emergency preparedness plan and policies for the facility, has the potential to hinder staff response during a disaster. This deficient practice affected 72 residents, staff and visitors on the date of the survey. Findings include: On 1/16/18 from 9:30 AM to 5:00 PM, review of provided emergency plan, policy and procedures, revealed no substantiating documentation demonstrating the facility had a training program for staff based on the plan. Interview of 5 of 5 staff members on 1/4/18 from 9:00 AM - 2:30 PM revealed no specific training was conducted on the emergency plan or its contents, only training focused on where the plan was located. Reference: 42 CFR 483.73 (d) (1)	E 037	IDT will add the facility Emergency Preparedness plan to be reviewed/ audited by different department personnel quarterly to ensure compliance with Federal, State and local laws related to facilities training and testing plan. Any findings and or revisions needed will be brought through the facilities QAPI meeting Quarterly. Monitoring Beginning the week of 2/22/18, The Center Executive Director will designate an IDT member to review/ audit the facility Emergency Preparedness plan to ensure compliance with Federal, State and local laws weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met for the facilities policy and procedure related to the facilities training and testing plan. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance. Date of Compliance	
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing.	E 039		

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E 039	<p>Continued From page 10</p> <p>The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]</p> <p>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set</p>	E 039	<p>2/22/18</p> <p>E 039</p> <p><u>Corrective Actions</u> On or before 2/22/18 the facility will participate in an individual facility based full- scale exercise as a community event is not available to participate within the compliance date. The facility Center Executive Director, and Maintenance Director will be attending the Central District Healthcare Coalition 2/15/18 to collaborate and plan a community full scale exercise.</p> <p><u>Other residents affected</u> All residents are potentially affected by deficient practice.</p> <p><u>Facility Systems</u> The Center Executive Director and/or designee will coordinate a full scale disaster drill with the Idaho Healthcare Coalition on or before 2/22/18</p>		

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E 039	<p>Continued From page 11 of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to participate in two exercises which tested the emergency preparedness readiness of the facility. Failure to participate in full-scale, actual, or tabletop events has the potential to reduce the facility's effectiveness to provide continuation of care to residents during an emergency. This deficient practice affected 72 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>On 1/16/18 from 8:30 AM to 5:00 PM, review of provided emergency plan documents revealed documentation demonstrating the facility had participated in one (1) tabletop exercise of the emergency preparedness plan, policies and procedures.</p> <p>Interview of the Administrator on 1/16/18 from 9:30 to 10:00 AM substantiated the facility had only participated in one tabletop event on a procedure identified in the emergency plan.</p> <p>Reference: 42 CFR 483.73 (d) (1)</p>	E 039	<p>The facility IDT will evaluate the outcomes and additional education will be provided.</p> <p>The Emergency Preparedness training and testing requirements will be reviewed monthly in the Safety QAPI meeting to ensure compliance with Federal, State and local laws related to the facilities Emergency Preparedness training and testing program. Any findings and or revisions needed will be brought through the facilities QAPI meeting Quarterly.</p> <p><u>Monitoring</u> The Center Executive Director and/or designee will monitor the effectiveness of the Emergency Management training through review and evaluation of the full scale exercise weekly for 4 weeks, and then monthly for 2 months to validate the facilities program meets and sustains requirements of facilities emergency preparedness policy and procedures. Any findings and or revisions needed will be brought through the facilities QAPI monthly at a minimum of 3 months. Center Executive Director will be responsible for compliance.</p> <p><u>Date of Compliance</u></p>	

2/22/18