



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

February 28, 2020

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 **February 21, 2020**, 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)

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 12, 2020**. Failure to submit an acceptable PoC by **March 12, 2020**, may result in the imposition of civil monetary penalties by **April 3, 2020**.

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 **March 27, 2020**, (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 **May 21, 2020**. A change in the seriousness of the deficiencies on **April 6, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **March 27, 2020**, includes the following:

Denial of payment for new admissions effective **May 21, 2020**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 21, 2020**, 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 **February 21, 2020**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

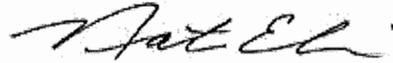
BFS Letters (06/30/11)

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

This request must be received by **March 12, 2020**. If your request for informal dispute resolution is received after **March 12, 2020**, 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: 02/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2020
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	INITIAL COMMENTS The facility consists of two (2) Type V (111) buildings. The east wing was constructed in 1979 and the west wing was built in 1986. Both buildings are fully sprinklered with an interconnected fire alarm/smoke detection system throughout. Each wing has its own Emergency Power Supply System (EPSS) on-site, natural gas, spark fired generator set. The facility is currently licensed for 148 SNF/NF beds and had a census of 64 on the date(s) of the survey. The following deficiencies were cited during the annual life safety code survey conducted on February 20 and 21, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare Apex Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure means of egress were maintained in accordance with NFPA 101. Failure to ensure means of	K 211	K 211 Corrective Actions The two potholes and removed asphalt were repaired on 3/9/2020. Other residents affected Residents, staff, and visitors utilizing the grounds of the facility have the potential to be affected.	

RECEIVED
MAR 12 2020
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 3/11/20

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 211	<p>Continued From page 1</p> <p>egress are not subject to rapid changes in elevation and are maintained to provide a nominally level walking surface, has the potential to expose residents to tripping hazards and subsequent falls. This deficient practice affected those residents using the grounds of the facility on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/20/20 from 1:00 - 1:30 PM, observation of a resident at the front grounds area, revealed she was using the front drive and walkway for exercise, walking the perimeter of the building. Further observation of the front parking area and the common path of travel leading from the parking area to the front door of the West wing, revealed two (2) potholes and removed asphalt creating substantial uneven depressions in the walking surface.</p> <p>Additionally, measurements of these holes taken at approximately 1:15 PM revealed that both areas measured approximately six inches deep from the top surface of the asphalt to the bottom of the hole and approximately twenty-four inches wide by forty-eight inches long.</p> <p>Actual NFPA standard:</p> <p>7.1.6 Walking Surfaces in the Means of Egress. 7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shall be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. 7.1.6.3 Level. Walking surfaces shall comply with</p>	K 211	<p><u>Facility Systems</u> An inspection of the facility grounds was completed 2/21/2020 by the Maintenance Director for other potholes and removed asphalt and any identified areas were repaired on 3/9/2020 The Center Executive Director and/or designee provided education on 3/5/2020 to the maintenance director related to the requirement of NFPA 101</p> <p><u>Monitoring</u> Beginning the week of 3/17/2020 The Maintenance Director and/or designee will conduct random audits of the facility drives and walkways 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> 3/17/2020</p>	

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K 211	Continued From page 2 all of the following: (1) Walking surfaces shall be nominally level. (2) The slope of a walking surface in the direction of travel shall not exceed 1 in 20, unless the ramp requirements of 7.2.5 are met. (3) The slope perpendicular to the direction of travel shall not exceed 1 in 48. 7.1.6.4* Slip Resistance. Walking surfaces shall be slip resistant under foreseeable conditions. The walking surface of each element in the means of egress shall be uniformly slip resistant along the natural path of travel.	K 211		
K 324 SS=D	<p>Cooking Facilities CFR(s): NFPA 101</p> <p>Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"> * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p>	K 324	<p>K 324</p> <p><u>Corrective Actions</u></p> <p>The facility obtained the records of the hydrostatic testing for the fire suppression system in the hood that was completed on 8/3/2017 by Johnson Controls. On 3/9/2020 the facility maintenance staff installed a metal angle piece to bridge the gap noted on the west wing kitchen hood.</p> <p><u>Other residents affected</u> All residents, staff, and visitors have the potential to be affected.</p> <p><u>Facility Systems</u> The Center Executive Director and/or designee provided education on 3/5/2020 to the maintenance staff related to the requirement of NFPA 96 and NFPA 17A</p>	

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review and observation, the facility failed to ensure the Kitchen hood filtration and the installed fire suppression system, was maintained in accordance with NFPA 96 and NFPA 17A. Failure to ensure the suppression system hydrostatic test is conducted as required and that all grease laden vapors are captured in the hood filter system, has the potential to hinder system response and increase the risk of grease fires due to system grease buildup not captured by filtration. This deficient practice affected staff of the kitchen on the date(s) of the survey. Findings include: 1) During record review of provided maintenance and inspection records conducted on 2/20/20 from 8:45 - 11:00 AM, records provided indicated the hydrostatic test for the fire suppression system in the hood was last completed in 2005. As of 2/26/20, no further documentation was provided indicating this system was hydrostatic tested within the past 12 years. 2) During the facility tour conducted on 2/20/20 from 1:00 - 3:00 PM, observation of the hood filters installed in the west wing Kitchen, revealed two (2) gaps, one that measured approximately one-half inch wide from top to bottom and the other that measured approximately one-half inch at the bottom, being reduced to no gap at the top of the filter. Actual NFPA standard: NFPA 96	K 324	<u>Monitoring</u> Beginning the week of 3/17/2020, The Maintenance Director and/or designee will conduct random audits of the facilities kitchen hood 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> 3/17/2020	

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K 324	Continued From page 4 6.2.3 Grease Filters. 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters. 7.5* Hydrostatic Testing. 7.5.1 The following parts of wet chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (1) Wet chemical containers (2) Auxiliary pressure containers (3) Hose assemblies Exception No. 1: Auxiliary pressure containers not exceeding 2 in. (0.05 m) outside diameter and less than 2 ft (0.6 m) in length. Exception No. 2: Auxiliary pressure containers bearing the DOT "3E" marking.	K 324	K 345 <u>Corrective Actions</u> The facility was able to obtain records demonstrating all devices were annually on 4/5/2019 and 8/14/2019 by Tyco SimplexGrinnell. The facility was able to obtain records to show that the five-year sensitivity testing was completed on 2/20/2018. On 2/24/2020 Johnson Controls tested the "failed" devices noted on the report dated April 5, 2019, in which it did pass.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire alarm systems were maintained in accordance with NFPA 72. Failure to test and maintain fire alarm systems as required, has the potential to limit early detection of fires and hinder staff response during these events. This deficient practice affected 64 residents and staff on the date(s) of the survey.	K 345	<u>Other residents affected</u> All residents, staff, and visitors have the potential to be affected. <u>Facility Systems</u> The Center Executive Director and/or designee provided education on 3/5/2020 to the maintenance staff related to the requirement NFPA 72 Inspection, Testing, and Maintenance of the fire alarm system.	

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K 345	<p>Continued From page 5</p> <p>Findings include:</p> <p>During review of provided fire alarm system maintenance and inspection records conducted on 2/20/20 from 8:45 - 11:00 AM, records indicated the vendor had conducted two (2) inspections and testing of the facility's fire alarm/smoke detection system. The first report was dated August 22, 2018 and a second inspection and testing dated April 5, 2019. Each report demonstrated inspection and testing of only a portion of the installed devices and not all devices on each occasion.</p> <p>Further review of these reports revealed the lack of documentation for the following:</p> <ul style="list-style-type: none"> - No record was available demonstrating all devices were tested annually as the portion of devices tested in April, 2019 would have been due in April 2020 and no report was available for that period. - No record of a sensitivity testing completed within the past five years. - No documentation demonstrating "failed" devices noted on the report dated April 5, 2019 were repaired and/or re-tested prior to the date of the survey. <p>When asked at approximately 10:45 AM if he knew whether the failed duct detector had been repaired, the Maintenance Supervisor stated he was not aware if the repair had been completed or the device inspected and tested prior to the date of the survey.</p> <p>As of 2/26/20, no further documentation was provided demonstrating these deficiencies were remedied.</p>	K 345	<p><u>Monitoring</u></p> <p>Beginning the week of 3/17/2020, The Maintenance Director and/or designee will conduct random audits of the facility maintenance records to ensure supporting documentation weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met.</p> <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> 3/17/2020</p>	

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K 345	Continued From page 6 Actual NFPA standard: Chapter 14 Inspection, Testing, and Maintenance 14.1 Application. 14.1.1 The inspection, testing, and maintenance of systems, their initiating devices, and notification appliances shall comply with the requirements of this chapter. 14.4.5.3* In other than one- and two-family dwellings, sensitivity of smoke detectors and single- and multiple-station smoke alarms shall be tested in accordance with 14.4.5.3.1 through 14.4.5.3.7. 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.	K 345	K 353 <u>Corrective Actions</u> The facilities maintenance director completed an inspection and secured the wrench for the PIV located outside the common area of the grounds on 2/22/2020 <u>Other residents affected</u> All residents, staff, and visitors have the potential to be affected. <u>Facility Systems</u> The maintenance staff will conduct monthly inspections of the supervised control valves beginning on 3/17/2020 The Center Executive Director and/or designee provided education on 3/5/2020 to the maintenance staff related to the NFPA 13.3.2 Inspections, 13.3.1 all valves shall be inspected weekly, 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		

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K 353	<p>Continued From page 7</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25. Failure to perform inspections of control valves as required, has the potential to hinder system response during a fire event. This deficient practice affected 64 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p> <p>1) During review of provided maintenance and inspection records conducted on 2/20/20 from 8:45 - 11:00 AM, no records were available for the weekly or monthly inspection of control valves.</p> <p>2) During the facility tour conducted on 2/20/20 from 1:00 - 4:00 PM, observation of the post indicator valve (PIV) located in the outside common area grounds on the west side of the west wing, revealed the wrench for the PIV was not secured to the valve staple by a lock. Interview of the Maintenance Supervisor at the time of this observation established he was unaware of the requirement to secure the wrench.</p> <p>Actual NFPA standard:</p>	K 353	<p><u>Monitoring</u> Beginning the week of 3/17/2020, 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> 3/17/2020</p>

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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 353	Continued From page 8 13.3.2 Inspection. 13.3.2.1 All valves shall be inspected weekly. 13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.	K 353	K 511	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with NFPA 70 and approved, listed assemblies such as UL 1363 XYBS. Failure to provide safe electrical installations has the potential to expose residents to the risks of arc fires and possible electrical shock. This deficient practice affected staff of the main Laundry on the date(s) of the survey. Findings include: During the facility tour conducted on 2/20/20 from 1:00 - 4:00 PM, observation of installed electrical appliances in the Laundry in the West wing, revealed a label maker for identifying resident clothing plugged into a relocatable power tap	K 511	Corrective Actions The facility's laundry director removed the labeling machine from the RPT and plugged the labeling machine into the wall on 2/20/2020. Other residents affected All residents, staff, and visitors have the potential to be affected. Facility Systems An inspection was completed on 3/5/2020 by the Maintenance Director to ensure any RPT's in the center were being used in accordance with NFPA 70. The Center Executive Director and/or designee provided education on 3/5/2020 to the IDT and maintenance staff related to any RPT's in the center are used in accordance with NFPA 70	

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K 511	<p>Continued From page 9 (RPT). Asked at the time of this observation if the label maker was a heat-producing appliance, the staff on duty stated "yes".</p> <p>Actual NFPA standard:</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment.</p> <p>(A) Examination. In judging equipment, considerations such as the following shall be evaluated:</p> <p>(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 may be evidenced by listing or labeling.</p> <p>(2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided</p> <p>(3) Wire-bending and connection space</p> <p>(4) Electrical insulation</p> <p>(5) Heating effects under normal conditions of use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled</p>	K 511	<p><u>Monitoring</u></p> <p>Beginning the week of 3/17/2020, 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> <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>3/17/2020</p>

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K 511	Continued From page 10 equipment shall be installed and used in accordance with any instructions included in the listing or labeling. ARTICLE 400 Flexible Cords and Cables 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage Additional reference: UL 1363 XYBS	K 511	K 918 <u>Corrective Actions</u> The facility was able to locate the supporting documentation related to the monthly load testing for the pre-existing installation for the months of January, February, and April of 2019. The facility was able to locate the supporting documentation related to the load testing of the new installation that came online in February 2019 for the month of April of 2019. The preexisting generator that is now located on the east side of the center has had a weekly inspection completed by the maintenance director on 2/26/2020 and weekly thereafter. The new generator that is located on the west side of the center has had a weekly inspection completed by the maintenance director on 2/26/2020 and weekly thereafter. Both the preexisting and the new generator will have a 4-hour load test conducted by Power Systems West on 3/17/2020. <u>Other residents affected</u> All residents, staff, and visitors have the potential to be affected.	
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and	K 918		

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K 918	<p>Continued From page 11</p> <p>transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply System (EPSS) generators were maintained in accordance with NFPA 110. Failure to inspect weekly, exercise monthly and conduct load testing as defined under the standard, has the potential to hinder continuity of care for residents during an extended power loss requiring use of the EPSS generator. This deficient practice affected 64 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p>	K 918	<p><u>Facility Systems</u></p> <p>An inspection was completed on 2/26/2020 by the Maintenance Director for both the preexisting and the new generator.</p> <p>The Center Executive Director and/or designee provided education on 3/5/2020 to maintenance staff related to the requirement of NFPA 110</p> <p><u>Monitoring</u></p> <p>Beginning the week of 3/17/2020, The Maintenance Director and/or designee will conduct random audits of the weekly inspection to ensure supporting documentation weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met.</p> <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>3/17/2020</p>

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K 918	<p>Continued From page 12</p> <p>During review of provided maintenance and inspection records for the two (2) installed EPSS generators conducted on 2/20/20 from 8:45 - 11:00 AM, it was determined the facility had replaced 1 of 2 generators and installed a new replacement system in February of 2019. Further review revealed the following missing documentation for the maintenance and testing of those installations:</p> <ul style="list-style-type: none"> - No load exercises completed for the pre-existing installation for the months of January, February and April of 2019. - No load exercises completed for the new installation that came online in February of 2019, for the month of April of 2019 - No weekly inspection(s) for the pre-existing installation for the week(s) of March 3, 2019; March 24, 2019; March 31, 2019; May 26, 2019; October 6, 2019; October 13, 2019; October 20, 2019; November 10, 2019; November 17, 2019; December 1, 2019; December 8, 2019; December 22, 2019 and December 29, 2019. - No weekly inspection(s) for the new installation for the week(s) of February 24, 2019; March 3, 2019; March 24, 2019; March 31, 2019; October 6, 2019; October 13, 2019; October 20, 2019; November 10, 2019; November 17, 2019; December 1, 2019; December 8, 2019; December 22, 2019 and December 29, 2019. - No documentation of a 4-hour load testing conducted for the pre-existing generator installation within the past three years. <p>Interview of the Maintenance Supervisor conducted on 2/20/20 at approximately 2:45 PM established he was not aware of any missing documentation for the generator set(s) and was not aware the 4-hour load test was required.</p>	K 918		

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K 918	Continued From page 13 As of 2/26/20, no further documentation establishing the documentation met the requirements of NFPA 110 was provided. Actual NFPA standard: NFPA 110 Chapter 8 Routine Maintenance and Operational Testing 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.9* Level 1 EPSS shall be tested at least once within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours.	K 918	K 923 <u>Corrective Actions</u> On 2/24/2020 the oxygen company secured the cryogenic liquid oxygen cylinder noted in the oxygen Trans fill room on the 500 west hall. On 2/20/2020 the Maintenance director removed and secured the "A" size oxygen cylinder noted in the Central Supply area on the west wing. <u>Other residents affected</u> All residents, staff, and visitors have the potential to be affected. <u>Facility Systems</u> An inspection was completed on 2/24/2020 by the Maintenance Director to ensure all oxygen cylinders in the facility were secured by either a chain or rack per NFPA 99 The Center Executive Director and/or designee provided education on 3/5/2020 to the IDT and maintenance staff related to the requirement of NFPA 99	
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. >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	K 923		

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K 923	<p>Continued From page 14</p> <p>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</p> <p>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)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, the facility failed to ensure medical gas cylinders such as oxygen, were maintained in accordance with NFPA 99. Failure to ensure oxygen cylinders were secured by a chain or placed in a rack, has the potential to expose residents to the increased risk of fires and explosions historically linked to compressed gas cylinders. This deficient practices affected 19 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/20/20 from</p>	K 923	<p><u>Monitoring</u></p> <p>Beginning the week of 3/17/2020, 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> <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>3/17/2020</p>

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K 923	<p>Continued From page 15</p> <p>1:00 - 4:00 PM, observation of the oxygen transfill room in the 500 west hall revealed one (1) unsecured cryogenic liquid oxygen (LOX) cylinder.</p> <p>Further observation of the Central Supply area in the West wing, revealed an "A" size oxygen cylinder, not secured in a rack or by a chain.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>5.1.3.3.2* Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements:</p> <p>(1) They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1.</p> <p>(2) They shall be secured with lockable doors or gates or otherwise secured.</p> <p>(3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits.</p> <p>(4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating.</p> <p>(5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations.</p> <p>(6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required.</p> <p>(7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty.</p>	K 923		

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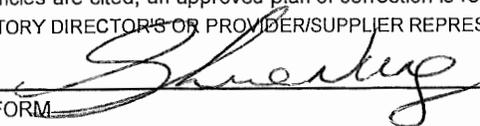
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K 923	<p>Continued From page 16</p> <p>(8)*They shall be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 6.</p> <p>(9) They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials.</p> <p>(10) They shall protect electrical devices from physical damage.</p> <p>11.7.3.3* Liquid oxygen base reservoir containers shall be secured by one of the following methods while in storage or use to prevent tipping over caused by contact, vibration, or seismic activity:</p> <p>(1) Securing to a fixed object with one or more restraints</p> <p>(2) Securing within a framework, stand, or assembly designed to resist container movement</p> <p>(3) Restraining by placing the container against two points of contact</p>	K 923		

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C 000	<p>INITIAL COMMENTS</p> <p>The facility consists of two (2) Type V (111) buildings. The east wing was constructed in 1979 and the west wing was built in 1986. Both buildings are fully sprinklered with an interconnected fire alarm/smoke detection system throughout. Each wing has its own Emergency Power Supply System (EPSS) on-site, natural gas spark fired generator set. The facility is currently licensed for 148 SNF/NF beds and had a census of 64 on the date(s) of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on February 20 and 21, 2020. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare Apex Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p> <p style="text-align: right;">RECEIVED MAR 12 2020 FACILITY STANDARDS</p>	
C 367	<p>02.108,07,b,iv Facility and Grounds Maintenance</p> <p>iv. Storage areas, attics, basements, and grounds shall be kept free from refuse, litter, weeds, or other items detrimental to the health, safety or welfare of the patients/residents.</p> <p>This RULE: is not met as evidenced by: Based on observation, the facility failed to ensure the grounds were maintained free of materials detrimental to the health and safety of the residents. Failure to control laundry dryer</p>	C 367	<p>C 367</p> <p><u>Corrective Actions</u></p> <p>The facilities maintenance director removed the excessive amount of lint debris noted on the grounds and over the top of the main gas shut-off on the west side on the west wing on 2/24/2020.</p>	

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

Administrator

(X6) DATE

3/11/20

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C 367	Continued From Page 1 discharge to prevent excessive build-up on the grounds accessible by the residents, has the potential to expose residents to airborne contaminants and the risk of fires from flammable substances. This deficient practice affected those residents and staff using the west wing exterior common area on the date(s) of the survey. Findings include: During the facility tour conducted on 2/21/20 from 8:30 - 10:00 AM, observation of the exterior of the laundry on the west side of the west wing, revealed the discharge exhaust for the laundry dryers, produced an excessive amount of lint debris on the grounds and over the top of the main gas shut-off for the west wing. Further examination of the size and depth of the lint deposited on the ground, revealed a section approximately fourteen feet long by eight feet wide and up to a quarter of an inch deep. Acutal IDAPA standard: iv. Storage areas, attics, basements, and grounds shall be kept free from refuse, litter, weeds, or other items detrimental to the health, safety or welfare of the patients/residents.	C 367	<u>Other residents affected</u> Residents, staff, and visitors using the west wing have the potential to be affected. <u>Facility Systems</u> A weekly cleaning schedule has been implemented by the Maintenance Director on 2/24/2020 to ensure any noted excessive lint debris from the laundry exhaust is removed from the area. The Center Executive Director and/or designee provided education on 3/5/2020 to the maintenance staff related to ensuring the grounds are maintained free of material detrimental to the health and safety of residents, related to the control of the laundry dryer discharge to prevent excessive build-up on the grounds accessible to residents and the potential to expose residents to airborne contaminants and the risk of fires and flammable substances. <u>Monitoring</u> Beginning the week of 3/17/2020 The Maintenance Director and/or designee will conduct random audits of the exterior of the laundry on the west side of the west wing weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met. <u>Date of Compliance</u> 3/17/2020	
C 386	02.120,03,a Building/Equipment in Good Repair a. The building and all equipment shall be in good repair. This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to ensure the structure was maintained in good repair. Failure to enclose and repair damaged eaves and soffits of the building roof system, has the potential to allow birds, rodents and insects to enter the building, exposing	C 386		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2020
NAME OF PROVIDER OR SUPPLIER APEX CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704		
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C 386	<p>Continued From Page 2</p> <p>residents to those inherent risks. This deficient practice affected 64 residents and staff on the date(s) of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 2/20/20 from 1:00 - 3:00 PM, observation of the exterior common area separating the east and the west wing(s) revealed the soffit area of the East wing outside the 300 hall, had approximately fourteen feet of soffit vent missing, exposing the interior of the soffit and roof/attic space.</p> <p>Further observation of the west wing area outside the 600 hall, revealed the soffit area was detached from the roof framing and had sagged, exposing the interior of the soffit and roof/attic space. Additionally, this location was observed to have a bird's nest formed inside of the soffit.</p> <p>Actual IDAPA standard:</p> <p>03. General Building Requirements. An existing facility shall be of such character to be suitable for use as a facility. The facility will be subject to approval by the Department. Other requirements are as follows:</p> <p>a. The building and all equipment shall be in good repair.</p>	C 386	<p>C 386</p> <p><u>Corrective Actions</u> The Facilities Maintenance staff repaired the soffits on both the East wing outside of the 300 hall and the west wing outside of the 600 hall on 3/4/2020</p> <p><u>Other residents affected</u> All residents residing in the facility have the potential to be affected.</p> <p><u>Facility Systems</u> An inspection of the facility roof to ensure the eaves and soffits were in good repair was completed by the Maintenance Director on 3/4/2020. The Center Executive Director and/or designee provided education on 3/5/2020 to the maintenance staff related to the requirement of ensuring the facility structure is maintained in good repair.</p> <p><u>Monitoring</u> Beginning the week of 3/17/2020 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></p>	

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



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

February 28, 2020

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

Provider #: 135079

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Ms. Nunez:

On **February 21, 2020**, an Emergency Preparedness 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 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. 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 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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 12, 2020**. Failure to submit an acceptable PoC by **March 12, 2020**, may result in the imposition of civil monetary penalties by **April 3, 2020**.

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 **March 27, 2020**, (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 . A change in the seriousness of the deficiencies on **April 13, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 27, 2020**, includes the following:

Denial of payment for new admissions effective **May 21, 2020**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 21, 2020**, 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 **February 21, 2020**, 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>

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

Sherrie Nunez, Administrator
February 28, 2020
Page 4 of 4

This request must be received by **March 12, 2020**. If your request for informal dispute resolution is received after **March 12, 2020**, 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

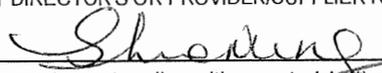
NE/lj
Enclosures

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 02/21/2020
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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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E 000	<p>Initial Comments</p> <p>The facility consists of two (2) Type V (111) buildings. The east wing was constructed in 1979 and the west wing was built in 1986. The facility is located within a municipal fire district with both county and state EMS services available. Both buildings are fully sprinklered with an interconnected fire alarm/smoke detection system throughout. Each wing has its own Emergency Power Supply System (EPSS) on-site, natural gas, spark fired generator set. The facility is currently licensed for 148 SNF/NF beds and had a census of 64 on the date(s) of the survey.</p> <p>The following deficiency was cited during the emergency preparedness survey conducted on February 20 and 21, 2020. 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 and Construction</p>	E 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare Apex Center does not admit that the deficiency listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p> <p style="text-align: center;">RECEIVED MAR 12 2020 FACILITY STANDARDS</p>	
E 041 SS=F	<p>Hospital CAH and LTC Emergency Power CFR(s): 483.73(e)</p> <p>(e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on</p>	E 041		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>3/11/20</i>
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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 041	<p>Continued From page 1 the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource</p>	E 041	<p>E 041</p> <p><u>Corrective Actions</u></p> <p>The facility was able to locate the supporting documentation related to the load testing for the preexisting installation for the months of January, February, and April of 2019.</p> <p>The facility was able to locate the supporting documentation related to the load testing of the new installation that came online in February 2019 for the month of April of 2019.</p> <p>The preexisting generator that is now located on the east side of the center has had a weekly inspection completed by the maintenance director on 2/26/2020 and weekly thereafter.</p> <p>The new generator that is located on the west side of the center has had a weekly inspection completed by the maintenance director on 2/26/2020 and weekly thereafter.</p> <p>Both the preexisting and the new generator will have a 4-hour load test conducted by Power Systems West on 3/17/2020.</p> <p><u>Other residents affected</u> All residents, staff, and visitors have the potential to be affected.</p>		

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E 041	<p>Continued From page 2</p> <p>Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Power Supply</p>	E 041	<p><u>Facility Systems</u></p> <p>An inspection was completed on 2/26/2020 by the Maintenance Director for both the preexisting and the new generator.</p> <p>The Center Executive Director and/or designee provided education on 3/5/2020 to maintenance staff related to the requirement of NFPA 110</p> <p><u>Monitoring</u></p> <p>Beginning the week of 3/17/2020, The Maintenance Director and/or designee will conduct random audits of the weekly inspection to ensure supporting documentation weekly for 4 weeks, and then monthly for 2 months to validate the requirement is met.</p> <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>3/17/2020</p>	

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

Printed: 02/27/2020
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 02/21/2020	
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E 041	<p>Continued From page 3</p> <p>System (EPSS) generators were maintained in accordance with NFPA 110. Failure to inspect weekly, exercise monthly and conduct load testing as defined under the standard, has the potential to hinder emergency response and continuity of care for the 64 residents, staff and visitors housed on the date(s) of the survey.</p> <p>Findings include:</p> <p>During review of provided maintenance and inspection records for the two (2) installed EPSS generators conducted on 2/20/20 from 8:45 - 11:00 AM, it was determined the facility had replaced 1 of 2 generators, installing a new replacement system in February of 2019. Further review revealed the following missing documentation for the maintenance and testing of those installations:</p> <ul style="list-style-type: none"> - No load exercises completed for the pre-existing installation for the months of January, February and April of 2019. - No load exercises completed for the new installation that came online in February of 2019, for the month of April of 2019 - No weekly inspection(s) for the pre-existing installation for the week(s) of March 3, 2019; March 24, 2019; March 31, 2019; May 26, 2019; October 6, 2019; October 13, 2019; October 20, 2019; November 10, 2019; November 17, 2019; December 1, 2019; December 8, 2019; December 22, 2019 and December 29, 2019. - No weekly inspection(s) for the new installation for the week(s) of February 24, 2019; March 3, 2019; March 24, 2019; March 31, 2019; October 6, 2019; October 13, 2019; October 20, 2019; November 10, 2019; November 17, 2019; December 1, 2019; December 8, 2019; December 22, 2019 and December 29, 2019. 	E 041		

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E 041	<p>Continued From page 4</p> <p>- No documentation of a 4-hour load testing conducted for the pre-existing generator installation within the past three years.</p> <p>Interview of the Maintenance Supervisor conducted on 2/20/20 at approximately 2:45 PM established he was not aware of any missing documentation for the generator set(s) and was not aware the 4-hour load test was required.</p> <p>As of 2/26/20, no further documentation substantiating compliance was provided.</p> <p>Reference: 42 CFR 483.73 (e) (1)</p>	E 041			