



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

March 8, 2019

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 **March 1, 2019**, 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. 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 **March 21, 2019**. Failure to submit an acceptable PoC by **March 21, 2019**, may result in the imposition of civil monetary penalties by **April 12, 2019**.

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 **April 5, 2019**, (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 30, 2019**. A change in the seriousness of the deficiencies on **April 15, 2019**, 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 **April 5, 2019**, includes the following:

Denial of payment for new admissions effective **June 1, 2019**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 1, 2019**, 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 **March 1, 2019**, 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:

Sherrie Nunez, Administrator
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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:

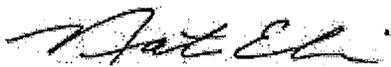
BFS Letters (06/30/11)

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

This request must be received by **March 21, 2019**. If your request for informal dispute resolution is received after **March 21, 2019**, 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
Enclosure

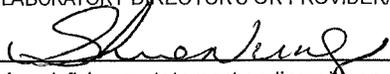
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135079	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2019
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NAME OF PROVIDER OR SUPPLIER 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 breezeway. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinklered 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 71 on the date of the survey.</p> <p>The following deficiencies were cited during the annual life safety code survey conducted on March 1, 2019. 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 and Construction</p>	K 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 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 321 SS=D	<p>Hazardous Areas - Enclosure CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p>	K 321	<p>K 321</p> <p><u>Corrective Actions</u></p> <p>The facilities maintenance director installed self-closures to the doors in rooms, 404, 406, 408, and corrected the double door leading from the corridor into the laundry room on the west side on 3/3/2019</p> <p><u>Other residents affected</u></p>	

RECEIVED
MAR 20 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CED	(X6) DATE 3/18/19
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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.

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 03/01/2019
NAME OF PROVIDER OR SUPPLIER APEX CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8211 USTICK ROAD BOISE, ID 83704	
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K 321	<p>Continued From page 1</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure hazardous areas were equipped with fully self-closing doors. Failure to ensure that doors to hazardous areas fully self-close, has the potential to allow fire, smoke and dangerous gases to pass into corridors and affect the egress of occupants during a fire. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/1/19 from 11:00 AM - 3:00 PM, observation of the following doors demonstrated they would not fully self-close when activated:</p> <p>Unoccupied east wing rooms 404, 406 and 408 which had been converted to storage for mattresses and additional combustible storage. 1 of 2 of the double doors leading from the corridor into the Laundry room on the west side.</p>	K 321	<p>Residents, staff and visitors have the potential to be affected.</p> <p><u>Facility Systems</u> An inspection was completed by the Maintenance Director on 3/3/2019 to ensure any rooms converted to storage, and/ or hazardous areas were equipped with self -closing devices throughout the facility. The Center Executive Director and/or designee provided education on 3/13/19 to the maintenance staff related to the requirement of NFPA 101, Hazardous areas- enclosures.</p> <p><u>Monitoring</u> Beginning the week of 3/18/2019, 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 of NFPA 101, Hazardous areas- enclosures 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> 3/18/2019</p>	

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K 321	Continued From page 2	K 321		
K 511 SS=D	<p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.3 The doors shall be self-closing or automatic-closing.</p> <p>Utilities - Gas and Electric CFR(s): NFPA 101</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Failure to ensure relocatable power taps (RPTs) are used as listed and designed has the potential to increase the risk of arc fires in the facility. This deficient practice affected staff and visitors of the unoccupied east wing on the date of the facility.</p> <p>Findings include: During the facility tour conducted on 3/1/19 from</p>	K 511	<p>K 511</p> <p><u>Corrective Actions</u> The facilities Maintenance director removed the RPT that was daisy chained in the east wing business office on 3/1/2019</p> <p><u>Other residents affected</u> Staff and visitors of the unoccupied east wing have the potential to be affected.</p> <p><u>Facility Systems</u> An inspection was completed by the Maintenance Director and Administrator on 3/13/2019 to ensure relocatable power taps are used as listed and designed throughout the facility. The Center Executive Director and/or designee provided education on 3/13/2019 to the IDT and maintenance staff related to the use of relocatable power taps are not to be daisy chained and are used as listed and designed requirement.</p> <p><u>Monitoring</u> Beginning the week of 3/18/2019,</p>	

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K 511	<p>Continued From page 3</p> <p>11:00 AM - 3:00 PM, observation of the east wing Business office revealed a RPT daisy-chained (connected in series) to another RPT.</p> <p>Actual NFPA standard:</p> <p>NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved. 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.</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</p> <p>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>	K 511	<p>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>3/18/2019</p>	

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

Printed: 03/08/2019
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 03/01/2019
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K 511	Continued From page 4 (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. Additional reference: UL 1363 XBYS	K 511	K 927 <u>Corrective Actions</u> RM Mechanical replaced the exhaust fan in the oxygen storage/ trans filling area on 3/6/2019 <u>Other residents affected</u> 9 residents, staff and visitors in the smoke compartment have the potential to be affected. <u>Facility Systems</u> An inspection of both the oxygen storage/ trans filling areas was completed on 3/3/2019 by the Maintenance Director to ensure the mechanical ventilation was discharging air from the space. The Center Executive Director and/or designee provided education on 3/13/2019 to the maintenance director related to the requirement of NFPA 99, ensuring sufficient mechanical ventilation in the oxygen storage/ trans filling areas	
K 927 SS=E	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Transfilling liquid oxygen without sufficient mechanical ventilation has the potential to increase the risks of combustion and explosions.	K 927		

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 03/01/2019
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K 927	<p>Continued From page 5</p> <p>This deficient practice affected 9 residents, staff and visitors in 1 of 6 smoke compartments of the east wing on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/01/19 from 1:00 - 3:00 PM, observation of the oxygen storage/transfill area in the west 500 hall, revealed mechanical ventilation was provided, but would not discharge air from the space when tested.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft3 of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).</p>	K 927	<p><u>Monitoring</u></p> <p>Beginning the week of 3/18/2019, The Maintenance Director and/or designee will conduct random audits 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>3/18/2019</p>	

Bureau of Facility Standards

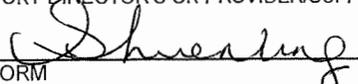
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2019
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C 000	<p>INITIAL COMMENTS</p> <p>The facility consists of two Type V (111) buildings that are separated by a breezeway. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinklered 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 71 on the date of the survey.</p> <p>The following deficiency was cited during the annual life safety code survey conducted on March 1, 2019. 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>C 442</p> <p><u>Corrective Actions</u></p> <p>The facilities maintenance director removed the portable heating unit from the east side riser room on 3/1/2019</p> <p><u>Other residents affected</u></p> <p>All residents, staff and visitors have the potential to be affected.</p> <p><u>Facility Systems</u></p> <p>An inspection was completed on 3/13/2019 by the Maintenance Director to ensure no other portable heating units were being used as a supplemental heat source</p> <p>The Center Executive Director and/or designee provided education on 3/13/2019 to the IDT and maintenance staff related to the requirement of the non- use of portable heating unit in the facility</p> <p><u>Monitoring</u></p> <p>Beginning the week of 3/18/2019, 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>	
C 442	<p>02.120,12,b Prohibited Use of Personal Comfort Heating</p> <p>b. Portable comfort heating devices shall not be used.</p> <p>This Rule is not met as evidenced by: Based on observation, the facility failed to ensure that portable heating devices, which are historically linked to facility fires, were not used as a supplemental heat source. Failure to ensure that portable heaters are not used for supplemental heat, potentially increases the risk of facility fires from these devices. This deficient</p>	C 442		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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STATE FORM  6699 YD3221  3/18/19 If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 03 - ENTIRE FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2019
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C 442	<p>Continued From page 1</p> <p>practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on 3/1/19 from 1:00 - 3:00 PM, observation of the east side riser room revealed a portable heater in use.</p> <p>Actual State IDAPA requirements: 16.03.02.120 120. EXISTING BUILDINGS. These standards shall be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance shall meet these standards. In the event of a change in ownership of a facility, the entire facility shall meet these standards prior to issuance of a new license.</p> <p>12. Heating. A heating system shall be provided for the facility that is capable of maintaining a temperature of seventy-five degrees (75F) to eighty degrees (80F) Fahrenheit in all weather conditions.</p> <p>b. Portable comfort heating devices shall not be used.</p>	C 442	<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>3/18/2019</p>	
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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

March 8, 2019

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 **March 1, 2019**, an Emergency Preparedness survey was conducted at Apex Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosure

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

PRINTED: 03/25/2019
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 03/01/2019
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
E 000	<p>Initial Comments</p> <p>The facility consists of two Type V (111) buildings that are separated by a breezeway and is located in a municipal fire district with both state and county EMS services available. The east building was built in 1979 and the west addition was built in 1986. The facility is fully sprinklered 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 Emergency Power Supply System is supported by an on-site, natural gas, spark fired generator. The facility is currently licensed for 148 SNF/NF beds and had a census of 71 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on February 28, 2019. 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		

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

TITLE

(X6) DATE

03/18/2019

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.