

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

PRINTED: 09/20/2019  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135079</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>07/30/2019</b> |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>APEX CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8211 USTICK ROAD</b><br><b>BOISE, ID 83704</b>                      |                      |   |
| (X4) ID PREFIX TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| F 000  | <p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was conducted July 30, 2019 at Apex Center. The facility was found to be in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Leader<br/>Jenny Walker, RN</p> | F 000   |   |                      |   |

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

TITLE

(X6) DATE

Electronically Signed

08/26/2019

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.



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 20, 2019

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

Provider #: 135079

Dear Ms. Nunez:

On **July 30, 2019**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008109**

ALLEGATION #1:

Staff were leaving residents in soiled briefs all day.

FINDINGS #1:

During the survey four resident records were reviewed, observations were conducted, facility grievances were reviewed, Resident Council minutes were reviewed, and staff and residents were interviewed.

Observations were conducted for staff providing personal care to incontinent residents in a timely manner.

The facility's grievances were reviewed from April 2019 to July 2019. There were no documented concerns with residents being left in soiled briefs for an extended amount of time. The Resident Council minutes were reviewed from April 2019 to July 2019. There were no documented concerns with residents not receiving personal care in a timely manner or being left in soiled briefs for an extended amount of time.

Three residents' records did not document concerns with residents being left in wet briefs all day. A fourth resident's record, admitted to the facility February 2015, documented a 1/16/19 behavioral contract between the facility and the Resident. The contract, initiated by the Resident, documented she would only allow staff to change her briefs three times in a 24-hour period and would only allow certain staff in her room to perform cares. A nurse progress note, dated 5/14/19, documented the Resident had refused to have her brief changed and chose to go to an outside medical appointment with wet briefs. An abuse investigation, dated 5/14/19, documented the incident was investigated and was unsubstantiated for abuse and neglect because the Resident chose not to have her brief changed. The investigation also documented the Resident was aware of the consequences and reiterated she did not want her brief changed.

Three residents were interviewed for staff providing personal care with no concerns identified.

Three CNAs and two nurses said residents were provided with appropriate incontinence care and concerns of neglect would be immediately reported to supervisors and the abuse coordinator, who was the administrator.

It could not be established the facility failed to provide incontinence care for residents. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

Staff were verbally abusive towards residents.

#### FINDINGS #2:

The facility's grievances were reviewed from April 2019 to July 2019. There were no documented allegations of abuse from staff members to residents. The facility's abuse reports were reviewed from April 2019 to July 2019. The abuse allegations were appropriately investigated by the facility.

Surveyors observed staff providing care and speaking to the residents appropriately. Three residents were interviewed to determine if staff had been verbally abusive towards them. They denied having any concerns with abuse.

Three residents' records did not document concerns with verbal abuse. A fourth resident's record, admitted to the facility February 2015, documented a verbal abuse investigation, dated 5/14/19, documented the incident was investigated and was unsubstantiated for abuse and neglect because the resident would not disclose what staff had said to them regarding potential verbal abuse.

Sherrie Nunez, Administrator  
September 20, 2019  
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Three CNAs, two nurses, the Director of Nursing Services (DNS), and the Administrator were interviewed for verbal abuse. The CNAs and nurses stated if they heard another staff member verbally abuse a resident, they would intervene and tell the staff member to leave the room or the area where the resident was and assure the resident was safe. The CNAs stated they would report the verbal abuse to the Administrator immediately and the charge nurse. The nurses stated if they witnessed a staff member verbally abusive towards a resident, they would remove the staff member from the resident and report the allegation of verbal abuse to the DNS and the Administrator. The DNS and the Administrator stated when they received an allegation of abuse, the staff member who was involved would be removed from the floor immediately and asked to write down what happened. The staff member would be suspended until the investigation was concluded. The DNS and the Administrator stated they would gather witness statements from residents and other staff members. They would interview the resident that was verbally abused, other residents if they have had a situation with the alleged staff member and would get staff interviews. After the investigation was complete, they would determine if the allegation could be substantiated or unsubstantiated. The Administrator stated they would also report the allegation of abuse to the State.

It could not be established the facility failed to respond to staff verbally abusing residents. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj

Sherrie Nunez, Administrator  
September 20, 2019  
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IDAHO DEPARTMENT OF  
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January 16, 2020

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

Provider #: 135079

Dear Ms. Nunez:

On **July 30, 2019**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00008193**

**ALLEGATION #1:**

The facility failed to respond to staff verbally abusing residents.

**FINDINGS #1:**

During the survey, 4 resident records were reviewed, observations were conducted, facility grievances were reviewed, facility abuse investigations were reviewed, and staff and residents were interviewed.

The facility's grievances from April 2019 to July 2019 were reviewed. The grievances did not include allegations of abuse from staff members to residents. The facility's abuse reports from April 2019 to July 2019 were reviewed. The reports documented appropriate investigation by the facility.

During observations, staff were noted to provide care and speak to the residents appropriately. 4 residents were interviewed and asked about staff being verbally abusive towards them. The residents stated staff had never been verbally abusive and staff provided timely assistance. One resident stated if staff was ever inappropriate towards residents, it would be reported immediately.

Three Certified Nursing Assistants (CNAs), 2 nurses, the Director of Nursing Services (DNS), and the Administrator were interviewed regarding verbal abuse. The CNAs and nurses stated if they heard another staff member verbally abuse a resident, they would intervene and tell the staff member to leave the room or the area where the resident was and assure the resident was safe. The CNAs stated they would report the verbal abuse to the charge nurse and Administrator immediately. The nurses stated if they witnessed a staff member being verbally abusive towards a resident, they would remove the staff member from the resident's area and report the allegation of verbal abuse to the DNS and the Administrator. The DNS and the Administrator stated when they receive an allegation of abuse, the staff member who was involved would be removed from the floor immediately and asked to write down what happened. The staff member would be suspended until the investigation was concluded. The DNS and the Administrator stated they would gather witness statements from residents and other staff members. They would interview the resident that was verbally abused, other residents, and staff. After the investigation was complete, they would determine if the allegation could be substantiated or unsubstantiated. The Administrator stated they would also report the allegation of abuse to the State.

It could not be established the facility failed to respond to staff verbally abusing residents. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

### **CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

### **ALLEGATION #2:**

The facility failed to ensure staff provided residents with incontinent care, which resulted in residents not participating in activities.

### **FINDINGS #2:**

Four residents' records were reviewed for incontinence care. Their records did not include documentation incontinent care was not provided. One of the 4 resident's records documented the resident was continent of bowel and bladder.

Sherrie Nunez, Administrator  
January 16, 2020  
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The resident stated she used the bathroom and did not need assistance with incontinence care. The resident's record was reviewed. Her record documented she was continent of bowel and bladder and had attended activities, including a facility barbeque on 7/24/19.

It could not be established that the facility failed to ensure staff provided residents with incontinent care, which resulted in residents not participating in activities. Therefore, the allegation was unsubstantiated, and no deficient practice was identified.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj