



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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

November 25, 2015

Monte Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Jones:

On **November 17, 2015**, a Facility Fire Safety and Construction survey was conducted at **Rexburg Care & Rehabilitation Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

Monte Jones, Administrator
November 25, 2015
Page 2 of 4

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 **December 8, 2015**. Failure to submit an acceptable PoC by **December 8, 2015**, may result in the imposition of civil monetary penalties by **December 28, 2015**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 22, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 22, 2015**. A change in the seriousness of the deficiencies on **December 22, 2015**, may result in a change in the remedy.

Monte Jones, Administrator
November 25, 2015
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **December 22, 2015**, includes the following:

Denial of payment for new admissions effective **February 17, 2016**.
42 CFR §488.417(a)

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 17, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 17, 2015**, 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:

Monte Jones, Administrator
November 25, 2015
Page 4 of 4

<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 **December 8, 2015**. If your request for informal dispute resolution is received after **December 8, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

Printed: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440
---	---

(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

K 000

The facility is a single story type V(111) construction built in 1988. The building is fully sprinklered with smoke detection in corridors and open spaces. There are multiple exits to grade. The facility is currently licensed for 119 beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on November 17, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The Survey was conducted by:

Nate Elkins
Health Facility Surveyor
Facility Fire Safety & Construction

RECEIVED

DEC - 4 2015

FACILITY STANDARDS

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Rexburg Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statement, 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 022 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E

K 022

K022

Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4

1) An exit sign will be added in the access corridor from room 200-201 on or before December 18, 2015 by our Maintenance Director.

2) A facility wide inspection will be performed by our Maintenance Director to identify and fix any areas where exit signs are needed on or before December 18, 2015.

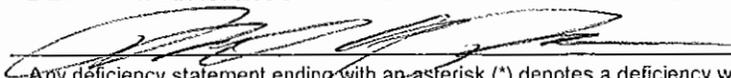
3) The maintenance director was reeducated by the administrator on NFPA standard for Exit signs on or before 12/18/2015.

This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure exit signs were visible from all areas within the facility exit access corridor system. Failure to provide exit signage can result

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

TITLE

(X6) DATE



Administrator

12-2-15

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.

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

Printed: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440
---	---

(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 022 Continued From page 1
in impeded or delayed evacuation in an emergency. This deficient practice affected 2 of 8 smoke compartments, 10 residents, staff and visitors on the day of the survey. The facility is licensed for 119 SNF/NF beds with a census of 36 on the date of survey.

Findings include:

During the facility tour on November 17, 2015 between 1:30 PM and 2:30 PM, observation revealed two areas in the 200 hallway where no exit sign was clearly visible. When observing the access corridor from room 200-201 looking East toward the nurse station it was revealed no exit signage was visible. Upon further evaluation of exit sign locations revealed an obstructed view of the exit signage near the intersection of the 200 hallway and main corridor near the dining room.

When asked, the Director of Plant Operations stated the facility was not aware the facility needed an extra exit sign but was aware of the exit sign near the intersection of the 200 hallway and main corridor near the dining room needed to be moved. These findings were acknowledged by the Director of Plant Operations and the Administrator at the exit conference.

Actual NFPA Standard:
Chapter 7 MEANS OF EGRESS
7.10.1.2* Exits.

Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.

K 025 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
Smoke barriers are constructed to provide at least a one half hour fire resistance rating in

K 022

4) Monthly rounds will be performed by the Maintenance Director for three months to identify any potential areas in need of exit signs and fix them. The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.

5) The Maintenance Director shall be responsible for compliance.

Compliance Date: 12/22/2015

K025

K 025

1) The following areas where there were penetrations in smoke barrier

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 025	<p>Continued From page 2</p> <p>accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and system performance during a fire event. This deficient practice affected 4 of 8 smoke compartments, staff, and visitors on the day of survey. The facility is licensed for 119 SNF/NF beds with a census of 36 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on November 17, 2015 at approximately 11:00 AM, observation of the smoke barrier wall in the attic space that separated the dining room and the Maintenance/laundry room area revealed a 4 inch water pipe penetrating through a 6 inch hole that was unsealed around the piping.</p> <p>2.) During the facility tour on November 17, 2015 at approximately 11:15 AM, observation of the smoke barrier wall separating the hallway from the Beautician room above the false ceiling tiles</p>	K 025	<p>walls: in the attic space that separated the dining room and the maintenance/laundry room area around a water pipe penetration, above the false ceiling tiles between the wall separating the hallway from the Beautician room around a water pipe, wall above the cross corridor doors in the 100 hallway around a water pipe penetration, in the sprinkler riser room there were two 2 inch holes in the wall and a penetration around a water pipe. These penetrations will be fixed on or before December 18th, 2015.</p> <p>2) A facility wide inspection will be performed by our Maintenance Director to identify any other penetrations in walls. The inspection will be completed on or before December 18th, 2015.</p> <p>3) The maintenance director was reeducated by the administrator on wall penetrations and the NFPA standard requirements on or before 12/18/2015.</p> <p>4) Monthly rounds will be performed by our Maintenance Director for three months to identify any potential wall penetrations and fix</p>

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

Printed: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 025	<p>Continued From page 3</p> <p>in the 100 hallway revealed a 4 inch water pipe penetrating through a 6 inch hole that was unsealed around the piping.</p> <p>3.) During the facility tour on November 17, 2015 at approximately 11:10 AM, observation of the smoke barrier wall above the cross corridor doors in the 100 hallway revealed a 4 inch pipe penetrating through a 6 inch hole that was unsealed around the pipe. This penetration was observed on both sides of the smoke wall.</p> <p>4.) During the facility tour on November 17, 2015 at approximately 2:30 PM, observation of the sprinkler riser room revealed a 4 inch water pipe penetrating though a 6 inch hole through the ceiling that was unsealed around the piping. Upon further investigation of the riser room revealed two 2 inch holes penetrating through the wall that was unsealed exposing the interior cavity of the wall.</p> <p>When asked about the open penetrations, the Director of Plant Operations revealed the facility was unaware of the open penetrations. These findings were acknowledged by the Director of Plant Operations and the Administrator at the exit conference.</p> <p>Actual NFPA standard:</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two</p>	K 025	<p>them. The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 12/22/2015</p>

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

Printed: 11/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440
---	---

(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 025 Continued From page 4
separate smoke compartments shall be provided on each floor.
Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.

K 025

8.3.2* Continuity.
Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.
Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier

K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=D
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029

K029
1) The corridor door to the Activity storage room located on the 100 hallway will be equipped with self-closing devices. Our Maintenance Director will complete this task on or before December 18th, 2015.
2) A facility wide inspection will be performed by our Maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 029	<p>Continued From page 5</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected 1 of 8 smoke compartments, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds with a census of 36 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on November 17, 2015 at approximately 11:15 AM, observation and operational testing revealed the door to the Activity storage room located in the 100 hallway was not on a self-closure. Observation of the room revealed it was used for storage of combustible supplies in high quantities. When asked, the Director of Plant Operations stated the facility was unaware the door needed to be on a self-closure. This finding was acknowledged by the Director of Plant Operations and the Administrator at the exit conference.</p> <p>Actual NFPA standard: NFPA 101, 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 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the</p>	K 029	<p>Director to identify any other corridor doors that should be equipped with self-closing devices but do not. This inspection will be performed on or before December 18th, 2015.</p> <p>3) The maintenance director was reeducated by the administrator on corridor door requirements to have self-closing devices on or before 12/18/2015.</p> <p>4) Monthly rounds will be performed by our Maintenance Director for three months to identify any potential corridor doors that do not meet the requirement.</p> <p>The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 12/22/2015</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 029	Continued From page 6 sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard	K 029	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit access was readily accessible at all times. Failure to provide readily accessible exit access could inhibit the safe evacuation of residents and during an emergency. This deficient practice affected residents, staff and visitors utilizing the enclosed	K 038	K038 1) The door leading to/from the Activity room into the enclosed courtyard will have the throw-bolt lock removed by our Maintenance Director on or before December 18 th , 2015. 2) A facility wide inspection will be performed by our Maintenance Director to identify any other doors that have the throw-bolt lock. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 038	<p>Continued From page 7</p> <p>courtyard on the date of the survey. The facility is licensed for 119 SNF/NF beds with a census of 36 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on November 17, 2015 at approximately 1:15 PM, observation of the door leading to/from the Activity room into the enclosed courtyard revealed a throw-bolt lock installed on the interior upper part of the door. When asked, the Director of Plant Operations revealed the facility was not aware of the throw-bolt lock. This finding was acknowledged by the Director of Plant Operations and the Administrator at the exit conference.</p> <p>Actual NFPA Standard: 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy.</p>	K 038	<p>inspection will be performed on or before December 18th, 2015.</p> <p>3) The maintenance director was reeducated by the administrator on door lock requirements on or before 12/18/2015.</p> <p>4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any potential door lock issues that do not meet the requirements.</p> <p>The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 12/22/2015</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440
---	---

(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 038 Continued From page 8
(b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows:
THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED
(c) The locking device is of a type that is readily distinguishable as locked.
(d) A key is immediately available to any occupant inside the building when it is locked.
Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause.
Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.

K 038

K 064 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10

K 064

K064

1) A required class B fire extinguisher will be installed in the kitchen by our Maintenance Director. This task will be completed on or before December 18th, 2015.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other areas that do not meet the requirement. This inspection will be performed on or before December 18th, 2015.

3) The maintenance director was educated by our Administrator on or

This Standard is not met as evidenced by:
Based on observation and interview it was determined that the facility did not ensure that portable fire extinguishers were distributed in accordance with NFPA 10. Failure to distribute extinguishers properly could delay the application of extinguishing agent and allow a fire to spread rapidly. This deficiency affected 1 of 8 smoke compartments, staff and visitors on the day of the survey. The facility is licensed for 119 SNF/NF beds with a census of 36 on the date of survey.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 064	Continued From page 9 During the facility tour on November 17, 2015 at approximately 2:30 PM, observation of the kitchen and the surrounding area revealed the facility did not have a required class B fire extinguisher (ABC) within 50 feet of the flammable liquid hazard. When asked, the Director of Plant Operations stated the ABC fire extinguisher was removed from the kitchen area prior to the survey date. This finding was acknowledged by the Director of Plant Operations and the Administrator at the exit conference. Actual NFPA standard: NFPA 10 3-3.1 Minimal sizes of fire extinguishers for the listed grades of hazard shall be provided on the basis of Table 3-3.1. Fire extinguishers shall be located so that the maximum travel distances do not exceed those specified in the table used. (See Appendix E.) See table 3-3.1 Fire Extinguisher Size and Placement for Class B Hazards	K 064	before December 18 th , 2015 on the life safety code for fire extinguishers. 4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any potential fire extinguisher issues that do not meet the requirements. The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months. 5) The Maintenance Director shall be responsible for compliance. Compliance Date: 12/22/2015
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to complete 4-year interval testing for the dampers as required under NFPA 90A. Failure to	K 067	K067 1) A 4-year interval test of the dampers will be scheduled. Our Maintenance Director will complete this work on or before 12/22/2015. 2) The Maintenance Director will set up a regular 4-year interval schedule for the testing of the dampers. This will be completed on or before 12/22/2015.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2015
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH 2ND ST WEST REXBURG, ID 83440	
(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 067	<p>Continued From page 10</p> <p>ensure dampers will operate to manufacturer's specifications would allow smoke and dangerous gases to pass freely throughout the facility during a fire event. This deficient practice affected 8 of 8 smoke compartments 36 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds with a census of 36 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on November 17, 2015 at approximately 9:30 AM, the facility failed to provide a 4-year interval testing report of the dampers. When asked, the Director of Plant Operations stated the facility was unaware of the damper testing requirements. This finding was acknowledged by the Director of Plant Operations and the Administrator at the exit conference.</p> <p>Actual NFPA standard:</p> <p>NFPA 90A 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p>	K 067	<p>3) The maintenance director was educated by the Administrator on or before December 22nd, 2015 on regulations regarding damper testing.</p> <p>4) The maintenance director was educated by the Administrator on or before December 22nd, 2015 on regulations regarding damper testing.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 12/22/2015</p>