



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

March 31, 2016

Trevor Cardon, Administrator  
Madison Carriage Cove Short Stay Rehabilitation  
410 West 1st North  
Rexburg, ID 83440-1406

Provider #: 135140

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Cardon:

On **March 22, 2016**, a Facility Fire Safety and Construction survey was conducted at **Madison Carriage Cove Short Stay Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 13, 2016**. Failure to submit an acceptable PoC by **April 13, 2016**, may result in the imposition of civil monetary penalties by **May 3, 2016**.

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 **April 26, 2016**, (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 **April 26, 2016**. A change in the seriousness of the deficiencies on **April 26, 2016**, 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 26, 2016**, includes the following:

Denial of payment for new admissions effective **June 22, 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 **September 22, 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 **March 22, 2016**, 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 **April 13, 2016**. If your request for informal dispute resolution is received after **April 13, 2016**, 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

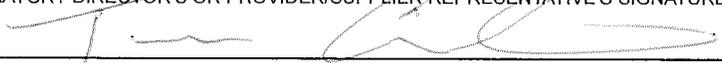
MPG/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b> B. WING _____ <i>RECEIVED</i>	(X3) DATE SURVEY COMPLETED  <b>03/22/2016</b>
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NAME OF PROVIDER OR SUPPLIER <b>MADISON CARRIAGE COVE SHORT STAY REI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH REXBURG, ID 83440</b> <i>APR 13 2016</i> <i>FACILITY STANDARDS</i>
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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><b>INITIAL COMMENTS</b></p> <p>Madison Carriage Cove Short Stay Rehabilitation is a single story with mechanical loft Type V (111) constructed, skilled nursing facility, that is approximately 35,874 square feet in size. Plans were approved in May of 2013 and construction completed in July of 2014. The facility was licensed for 20 beds in August 2014. The facility is co-located with a 20 bed Assisted Living facility without occupancy separation.</p> <p>The facility is fully sprinklered, with complete smoke detection and fire alarm system, type 2 Essential Electrical Service, piped medical gas, and is subdivided into three smoke compartments, with ten exits to grade.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 22, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy in accordance with 42 CFR 483.70.a</p> <p>The survey was conducted by:</p> <p>Nate Elkins Facility Fire Safety &amp; Construction</p>	K 000	<p><i>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</i></p> <p>K012</p> <p><b>What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?</b></p> <p>Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.</p> <p><b>How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</b></p> <p>All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.</p>	4/25/16
K 012 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.</p> <p>This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure smoke and fire barrier protection between two facilities, the main floor smoke compartments and mechanical loft. This deficient practice would allow smoke and heat in one area or space to move into and through smoke and fire</p>	K 012	<p>All unsealed conduits located in the assisted living dining room to the skilled nursing wing, the assisted living 100 hallway and the skilled nursing administration area, and the two conduits located in the communications room loft which communicated between floors have been sealed with a material that is capable of maintaining the smoke resistance of the smoke barrier in that room. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>FD</i>	(X6) DATE <i>4/21/16</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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K 012	<p>Continued From page 1</p> <p>compartments on all levels and spaces. This deficient practice affected all residents in the skilled nursing wing and the assisted living wing, along with staff and visitors on the date of survey. The skilled nursing is licensed for 20 SNF/NF beds with a census of 18 and the assisted living is licensed for 20 AL beds with a census of 15 and the on the day of survey.</p> <p>Findings Include:</p> <p>1.) During the facility tour on March 22, 2016 at approximately 10:30 AM, observation of the 2 hour fire wall at the assisted living dining room to the skilled nursing wing revealed an approximate 2 foot x 4 inch hole in the wall. When asked, the Environmental Services Director stated the facility was unaware of the hole in the wall.</p> <p>2.) During the facility tour on March 22, 2016 at approximately 10:45 AM, observation of the 2 hour fire wall at the assisted living 100 hallway and the skilled nursing administration area revealed two (2) 1 inch penetrations around a conduit pipe that were unsealed. When asked, the Environmental Services Director stated the facility was unaware of the penetrations in the wall.</p> <p>3.) During the facility tour on March 22, 2016 at approximately 1:30 PM, observation revealed two (2) unsealed conduits located in the communications room in the mechanical loft which communicated between floors. A strong and obvious movement of air was felt at each of the exposed conduit openings. These openings would allow smoke and heat to forcefully migrate. When asked about the unsealed penetrations, the Environmental Services Director was not aware of the unsealed conduits.</p>	K 012	<p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Maintenance Director or designee will perform a visual check at least quarterly to ensure the unsealed conduits located in the assisted living dining room to the skilled nursing wing, the assisted living 100 hallway and the skilled nursing administration, and the two conduits located in the communications room loft which communicated between floors remain sealed. Any unsealed conduit found during these inspections will be resealed as soon as possible.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.</p>	

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K 012	<p>Continued From page 2</p> <p>*This deficiency was previously sited during the initial medicare certification survey conducted on February 25 &amp; 26, 2015*</p> <p>Actual NFPA Standard:</p> <p>18.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 18.1.6.2. (See 8.2.1.)</p> <p>18.3.7.3 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 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 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.</p> <p>8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire</p>	K 012		

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K 012	Continued From page 3 Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided 8.2.2 Compartmentation. 8.2.2.1 Where required by Chapters 12 through 42, every building shall be divided into compartments to limit the spread of fire and restrict the movement of smoke. 8.2.2.2* Fire compartments shall be formed with fire barriers that are continuous from outside wall to outside wall, from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Walls used as fire barriers shall comply with Chapter 3 of NFPA 221, Standard for Fire Walls and Fire Barrier Walls. The NFPA 221 limitation on percentage width of openings shall not apply. Exception: A fire 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 has a fire resistance rating not less than that of the fire barrier. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following	K 012		

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K 012	Continued From page 4 conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 012		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain	K 018	K018  <b>What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?</b>  Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.  <b>How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</b>  All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.	4/25/16

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K 018	<p>Continued From page 5</p> <p>corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress during a fire event. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds with a census of 18 on the day of survey.</p> <p>Findings Include:</p> <p>1.) During the facility tour on March 22, 2016 at approximately 11:15 AM, observation of the entrance corridor revealed the 45 minute rated door to the Administrators Office that is equipped with an automatic door closure was blocked open by a metal object impeding the door from closing. When asked, the Environmental Services Director stated the facility was unaware the doors could not be blocked open.</p> <p>2.) During the facility tour on March 22, 2016 at approximately 11:30 AM, observation of the main corridor revealed the 45 minute rated door to the Rehabilitation Gym that is equipped with an automatic door closure was blocked open by a metal object impeding the door from closing. When asked, the Environmental Services Director stated the facility was unaware the doors could not be blocked open.</p> <p>3.) During the facility tour on March 22, 2016 at approximately 2:00 PM, observation of the main corridor revealed the 45 minute rated door to the Director of Social Services office that is equipped with an automatic door closure was blocked open by a rubber chock impeding the door from closing. When asked, the Environmental Services Director stated the facility was unaware the doors could not be blocked open.</p>	K 018	<p>The metal object blocking the door open to the administration office and all other potential blocking objects have been removed. The object impeding the door to the Rehabilitation Gym from closing and any other potential impeding objects have been removed. The object impeding the door to the Director of Social Services Office from closing and any other potential objects have been removed. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Maintenance Director or designee will perform a check at least quarterly of the doors of Administration Office door, Rehabilitation Gym, and the Director of Social Services to ensure that no object is impeding these doors from closing.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.</p>	

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K 018	Continued From page 6 Actual NFPA standard:  18.3.6.3* Corridor Doors. 18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  18.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  Also note: A.18.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers shall be constructed to provide at	K 025		

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NAME OF PROVIDER OR SUPPLIER <b>MADISON CARRIAGE COVE SHORT STAY REI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH REXBURG, ID 83440</b>		
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K 025	<p>Continued From page 7</p> <p>least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 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 during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds with a census of 18 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 22, 2016 at approximately 10:30 AM, observation of the smoke barrier wall near the Hair Salon, Private Patient Room and the 200 hallway revealed the following penetrations through the smoke barrier: Two (2) 1 inch penetrations around a conduit pipe that were unsealed. One (1) 3 inch penetration around a water pipe that was unsealed. Three (3) 2 inch penetrations that were unsealed.</p> <p>When asked, the Environmental Services Director stated the facility was unaware of the unsealed penetrations.</p> <p>Actual NFPA standard:</p> <p>18.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a</p>	K 025	<p>K025</p> <p><b>What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?</b></p> <p>Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.</p> <p><b>How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</b></p> <p>All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.</p> <p>All unsealed conduits located in the smoke barrier wall near the Hair Salon, Private Patient Room and the 200 hallway have been sealed with a material that is capable of maintaining the smoke resistance of the smoke barrier in that room. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Maintenance Director or designee will perform a visual check at least quarterly to ensure the unsealed conduits located at the smoke barrier wall near the Hair Salon, Private Patient Room and the 200 hallway remain sealed. Any unsealed conduit found during these inspections will be resealed as soon as possible.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.</p>	4/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/22/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>MADISON CARRIAGE COVE SHORT STAY REI</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 WEST 1ST NORTH REXBURG, ID 83440</b>		
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K 025	Continued From page 8 fire resistance rating of not less than 1 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 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.  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 025		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded core wood. Non- rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive	K 027	K027  <b>What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?</b>  Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.  <b>How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</b>  All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.	4/25/16

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K 027	<p>Continued From page 9</p> <p>latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8</p> <p>This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure smoke barrier doors resist the passage of smoke. Failure to ensure smoke barrier doors resist the passage of smoke would allow smoke and dangerous gases to move through the barrier endangering residents. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds with a census of 18 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on March 22, 2016 at approximately 2:00 PM, observation of the smoke barrier doors at the 2 hour separation leading from the skilled nursing administration area to the assisted living 100 hallway revealed the doors did not have installed astragals capable of resisting the passage of smoke. When asked, the Environmental Services Director stated the facility was unaware astragals were needed on smoke barrier doors.</p> <p>Actual NFPA Standard:</p> <p>18.3.7.8</p> <p>Rabbets, bevels, or astragals shall be required at the meeting edges, and stops shall be required at the head and sides of door frames in smoke barriers. Positive latching hardware shall not be required. Center mullions shall be prohibited.</p>	K 027	<p>An astragal capable of resisting passage of smoke has been installed on the door leading from the skilled nursing administration area to the assisted living 100 hallway. Maintenance Director has been in-serviced on this regulation. Staff has been in-serviced on this regulation and to record maintenance issues in the maintenance service log for repairs.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Maintenance Director or designee will perform a check at least quarterly on the door leading from the skilled nursing administration area to the assisted living 100 hallway to ensure the door to ensure the astragal installed on the door remains in good working condition and the fire doors close properly.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.</p>
K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected</p>	K 050	

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K 050	<p>Continued From page 10</p> <p>times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>This Standard is not met as evidenced by: Based upon record review, the facility failed to conduct fire drills one per shift per quarter. Failure to adequately train staff could hinder proper response during a fire or emergency event. This deficient practice affected all residents, staff, and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds with a census of 18 on the day of survey.</p> <p>Findings include:</p> <p>During record review on March 22, 2016, records revealed the facility did not conduct any fire drills during the third quarter. When asked, the Environmental Services Director stated the facility was aware of the missing third quarter drills. *This deficiency was previously sited during the initial medicare certification survey conducted on February 25 &amp; 26, 2015*</p> <p>Actual NFPA standard: NFPA 101- 2000 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns,</p>	K 050	<p>K050</p> <p><b>What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?</b></p> <p>Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.</p> <p><b>How will you identify other residents, staff, visitors or vendors having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</b></p> <p>All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.</p> <p>The Maintenance Director was in-serviced regarding the regulations on frequency and information needed for the fire drills.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <p>The Administrator or designee will perform a check of the fire drill log at least quarterly to ensure that each shift participates in a fire drill each quarter and the fire drills are completed each quarter per the regulations.</p> <p><b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur?</b></p> <p>The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly.</p>	4/25/16

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

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K 050	Continued From page 11 maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		