November 25, 2016

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, 2016, 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
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, 2016.** Failure to submit an acceptable PoC by **December 8, 2016,** may result in the imposition of civil monetary penalties by **December 28, 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. 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 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, 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 **December 22, 2016.** A change in the seriousness of the deficiencies on **December 22, 2016,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by December 22, 2016, includes the following:

Denial of payment for new admissions effective February 17, 2017.
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, 2017, 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 7; 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, 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:
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, 2016. If your request for informal dispute resolution is received after December 8, 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, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>135105</td>
<td>A. BUILDING 02 - ENTIRE NURSING FACILITY</td>
<td>11/17/2016</td>
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<td>B. WING</td>
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NAME OF PROVIDER OR SUPPLIER

REXBURG CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

660 SOUTH SECOND STREET WEST
REXBURG, ID 83440

SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
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<tr>
<td>K00</td>
<td></td>
<td>&quot;This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Rexburg Care &amp; 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.&quot;</td>
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<tr>
<td>K161</td>
<td></td>
<td>1) The following areas will be repaired for penetrations: mechanical/electrical room next to room 210 unsealed conduit pipe penetrating through the ceiling exposing the attic space, penetration around the back side of the pipe, communication room next to resident room 110 had 3 small penetrations next to the communications cables in the ceiling and laundry room penetration in the wall behind the washer on or before 11/17/2016</td>
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</table>

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

Administrator

12-1-16

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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>K 161</td>
<td>Continued From page 1</td>
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<td>3</td>
<td>II (000)</td>
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<td>Not allowed</td>
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<td>4</td>
<td>III (211)</td>
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<td>Maximum 2 stories</td>
<td>sprinklered</td>
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<td>6</td>
<td>V (111)</td>
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<td>7</td>
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<tr>
<td>8</td>
<td>V (000)</td>
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<td>Maximum 1 story sprinklered</td>
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Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations between compartments could allow fire, smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 38 on the day of the survey.

Findings include:

During the facility tour on November 17, 2016 from approximately 10:00 AM to 1:30 PM, December 20, 2016 by our Maintenance Director.

2) A facility wide inspection will be performed by our Maintenance Director to identify and fix any areas where there are penetrations on or before December 20, 2016.

3) The maintenance director was reeducated by the administrator on NFPA standard for penetrations on or before 12/20/2016.

4) Monthly rounds will be performed by the Maintenance Director for three months to identify any penetrations 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: 12/22/2016
K 161 Continued From page 2

observation of the following areas revealed unsealed penetrations:

Mechanical/Electrical room next to room 210 has an approximately 1-1/4" unsealed conduit pipe penetrating through the ceiling exposing the attic space above. Further observation revealed an approximately 1/2" penetration around the back side of the pipe.

Communication room next to resident room 110 revealed three (3) small penetrations approximately 1/2 Inch next to the communication cables in the ceiling.

Laundry room revealed an approximate 6" x 30" penetration in the wall behind the washer.

Interview with the Maintenance Supervisor revealed the facility was unaware of the penetrations

Actual NFPA standard:

19.1.6 Minimum Construction Requirements.
19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)

8.2 Construction and Compartmentation.
8.2.1 Construction.
8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.

K 222 NFPA 101 Egress Doors
K 222 Continued From page 3

**Egress Doors**

Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:

**CLINICAL NEEDS OR SECURITY THREAT LOCKING**

Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.

18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6

**SPECIAL NEEDS LOCKING ARRANGEMENTS**

Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.

18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4

**DELAYED-EGRESS LOCKING ARRANGEMENTS**

Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and

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1) The coded lock for the exit door by the laundry room will be disabled on or before December 20th, 2016.

The exit door from the dining room will be adjusted so that it will not exceed 15lbs of force to open on or before December 20th, 2016.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other exit doors that have a controlled access type lock. The inspection will be completed on or before December 20th, 2016.

A facility wide inspection will be performed by our Maintenance Director to identify any other exit doors that exceed the 15lbs of force to open on or before December 20th, 2016. Any findings will be adjusted/fixed to be brought into compliance.

3) The maintenance director was reeducated by the administrator on exit doors with controlled access type locks and exit doors that exceed 15lbs of force to open requirements on or before 12/20/2016.
K 222 continued from page 4

Ordinary hazards contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.

18.2.2.2.4, 19.2.2.2.4

Access-controlled egress locking arrangements

Access-controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.

18.2.2.2.4, 19.2.2.2.4

Elevator lobby exit access locking arrangements

Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.

18.2.2.2.4, 19.2.2.2.4

This standard is not met as evidenced by:

Based on observation, operational testing and interview, the facility failed to ensure that exit doors were arranged to be readily opened from the egress side and not require excessive force or special knowledge. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 38 on the day of the survey.

Findings include:

1.) During the facility tour on November 17, 2016 from approximately 10:00 AM to 1:30 PM, observation and operational testing revealed the exit door by the laundry room was equipped with
K 222 Continued From page 5

an controlled access type lock and could not be opened without special knowledge. (code) When asked, the Maintenance Supervisor stated the facility was unaware that controlled access exit door was not allowed.

2.) During the facility tour on November 17, 2016 from approximately 10:00 AM to 1:30 PM, observation and operational testing revealed the exit door from the dining room required excessive force exceeding 15 lbf to open. When asked, the Maintenance Supervisor stated the facility was not aware that the door was very hard to open.

Actual NFPA standard:

1.) 7.2.1.5 Locks, Latches, and Alarm Devices.
7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied.
7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.
7.2.1.4.5 Door Leaf Operating Forces.
7.2.1.4.5.1 The forces required to fully open any door leaf manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the leaf in motion, and 15 lbf (67 N) to open the leaf to the minimum required width, unless otherwise specified as follows:
(1) The opening forces for interior side-hinged or pivoted-swinging door leaves without closers shall not exceed 5 lbf
K 222 Continued From page 6
(22 N).
(2) The opening forces for existing door leaves in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile.
(3) The opening forces for horizontal-sliding door leaves in detention and correctional occupancies shall be as provided in Chapters 22 and 23.
(4) The opening forces for power-operated door leaves shall be as provided in 7.2.1.9.

K 223 NFPA 101 Doors with Self-Closing Devices

1) The door leading to the kitchen will be adjusted so that it will close without being impeded by a raised portion of the floor. Our Maintenance Director will complete this task on or before December 20th, 2016.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other self-closing doors that are impeded from closing and fix them. This inspection will be performed on or before December 20th, 2016.

3) The maintenance director was reeducated by the administrator on
K 223 Continued From page 7

hinder egress of occupants during a fire event. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds with a census of 38 on the day of the survey.

Findings include:

During the facility tour on November 17, 2016 from approximately 10:00 AM to 1:30 PM, observation and operational testing of the door leading to the Kitchen revealed the door was equipped with a self closing device and when operated the door was impeded by a raised portion of the floor not allowing the door to close completely. When asked, the Maintenance Supervisor stated the facility was unaware of the door.

Actual NFPA standard:

NFPA 101 19.2.2.7* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.

K 353 NFPA 101 Sprinkler System - Maintenance and K 353 K353

impeded self-closing doors on or before 12/20/2016.

4) Monthly rounds will be performed by our Maintenance Director for three months to identify any potential self-closing doors that are impeded from closing.

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: 12/22/2016
### K 353 Continued From page 8

**Testing**

Sprinkler System - Maintenance and Testing

Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.

a) Date sprinkler system last checked

b) Who provided system test

c) Water system supply source

Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.

9.7.5, 9.7.7, 9.7.8, and NFPA 25

This STANDARD is not met as evidenced by:

Based on observation and interview, the facility failed to maintain the sprinkler system. Failure to ensure the system was maintained properly could result in insufficient suppression during a fire event. This deficient practice affected 22 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 38 on the day of the survey.

Findings include:

During the facility tour on November 17, 2016, from approximately 10:00 AM to 1:30 PM, inspection of the following areas revealed the sprinkler escutcheon rings had shifted exposing penetrations in the ceiling around the sprinkler

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<tr>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</thead>
<tbody>
<tr>
<td>K 353</td>
<td>SS=E</td>
<td>Testing</td>
<td>1) Penetrations around sprinkler escutcheon rings will be fixed in the following identified areas: room across from Nurses Station in the 100 hallway, storage room next to resident room 220, bath next to resident room 211, chemical storage next to laundry room, office next to room 101 and occupational therapy kitchen. They will be fixed by our Maintenance Director on or before December 20th, 2016.</td>
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<td>2) A facility wide inspection will be performed by our Maintenance Director to identify any other penetrations around sprinkler escutcheon rings and any penetrations will be fixed. This inspection will be performed on or before December 20th, 2016.</td>
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<td>3) The maintenance director was reeducated by the administrator on penetrations around sprinkler escutcheon rings on or before 12/20/2016.</td>
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<td>4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any penetrations around sprinkler escutcheon rings.</td>
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</table>
K 353 Continued From page 9
assembly varying in size from 1/4" - 1/2":
  a. Room across from Nurse's Station in the
     100 Hallway.
  b. Storage room next to resident room 220
  c. Bath next to resident room 211
  d. Chemical storage next to laundry room
  e. Office next to room 101
  f. Occupational therapy kitchen
When asked, the Maintenance Supervisor stated
the facility was not aware that the sprinkler
escutcheon rings had shifted.

Actual NFPA standard:

NFPA 101
19.3.5.1 Buildings containing nursing homes shall
be protected
throughout by an approved, supervised automatic
sprinkler system in accordance with Section 9.7,
unless otherwise
permitted by 19.3.5.5.

9.7.1.1* Each automatic sprinkler system
required by another
section of this Code shall be in accordance with
one of the
following:
(1) NFPA 13, Standard for the Installation of
Sprinkler Systems
(2) NFPA 13D, Standard for the Installation of
Sprinkler Systems in
One- and Two-Family Dwellings and
Manufactured Homes
(3) NFPA 13R, Standard for the Installation of
Sprinkler Systems in
Residential Occupancies up to and Including Four
Stories in
Height

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: 12/22/2016
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 135105

**NAME OF PROVIDER OR SUPPLIER:** REXBURG CARE & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 660 SOUTH SECOND STREET WEST REXBURG, ID 83440

**SUMMARY STATEMENT OF DEFICIENCIES**

**K 353 Continued From page 10**

NFPA 13
6.2.7 Escutcheons and Cover Plates.
6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler.
6.2.7.2* Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly.
6.2.7.3 Cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly.

**K 363**

**SS=E**

Corridor - Doors
2012 EXISTING
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.

**K363**

1) The following corridor resident room doors will be adjusted to meet the requirement of resisting the passage of smoke: 101, 111, 118, 120, 121, 129, 203, 213, 223, 225, 227, 228, 229, 230 and 231. This task will be completed on or before December 20th, 2016.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other corridor resident room doors that do not meet the requirement. This inspection will be performed on or before December 20th, 2016.

3) The maintenance director was educated by our Administrator on or
K 363 Continued From page 11

Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.

19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485
Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

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 corridor doors could allow smoke and dangerous gases to pass freely between smoke compartments affecting egress and protection in place. This deficient practice has the potential to affect 22 residents, staff, and visitors on the date of survey. The facility is licensed for 119 SNF/NF beds with a census of 38 on the day of survey.

Findings include:

During the facility tour on November 17, 2016 between 10:00 AM and 1:30 PM, observation and operational testing of multiple corridor doors revealed the doors would not close and seal properly leaving a gap between the door and the door from ranging in size of approximately 1/4 inch to 1/2 inch that would not resist the passage of smoke at the following locations:

Room 101, Room 111, Room 118, Room 120, Room 121, Room 129, Room 203, Room 213, Room 223, Room 225, and Rooms 227 through 231.

K 363 before December 20th, 2016 on the life safety code for corridor resident room doors resisting the passage of smoke.

4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any potential corridor resident room doors 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: 12/22/2016
K 363 Continued From page 12

When asked, the Maintenance Supervisor stated the facility was unaware of the door gaps.

Actual NFPA Standards:
19.3.6.3* Corridor Doors.
19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following:
(1) 13/4 in. (44 mm) thick, solid-bonded core wood
(2) Material that resists fire for a minimum of 20 minutes

K 374 NFPA 101 Subdivision of Building Spaces - Smoke Barrie

1) The cross corridor doors near room 112/121 will be adjusted to close completely. Our Maintenance Director will complete this work on or before 12/20/2016.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other cross corridor doors that do not meet the requirement. This inspection will be performed on or before December 20th, 2016.

3) The maintenance director was educated by the Administrator on or
K 374 Continued From page 13

interview, the facility failed to ensure smoke barrier doors would close properly when activated by the smoke detection system. Failure to ensure that smoke compartment doors closed completely could allow the spread of fire and allow the movement of smoke from one side of the fire barrier to the other. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds with a census of 38 on the day of the survey.

Findings include:

During the facility tour on November 17, 2016, from approximately 10:00 AM to 1:30 PM, operational testing of the cross corridor doors near room 112/121 would not close completely when activated leaving an approximately 1/2 inch gap between the facing edge of the doors. When asked, the Maintenance Supervisor stated the facility was unaware of the doors not closing properly.

Actual NFPA standard:

NFPA 101
19.3.7.6 Openings in smoke barriers shall be protected using one of the following methods:
(1) Fire-rated glazing
(2) Wired glass panels in steel frames
(3) Doors, such as 13/4 in. (44 mm) thick, solid-bonded woodcore doors
(4) Construction that resists fire for a minimum of 20 minutes.
19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and

K 374 before December 26th, 2016 on regulations regarding smoke barrier doors in corridors.

4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any potential corridor doors that do not meet the requirements.

The results of these rounds will be reported to the center Performance Improvement (Pl) committee for three months.

5) The Maintenance Director shall be responsible for compliance.

Compliance Date: 12/22/2016
**K 374 Continued From page 14**

all of the following:

1. The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7.
2. Latching hardware shall not be required.
3. The doors shall not be required to swing in the direction of egress travel.

Doors in smoke barriers shall comply with 8.3.4 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.

**K 916**

NFPA 101 Electrical Systems - Essential Electric Syste

1) The alarm annunciator for the EES will be repaired/replaced. Our Maintenance Director will complete this work on or before 12/20/2016.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other alarm annunciator for the EES that are not operational. This inspection will be performed on or before December 20th, 2016.

3) The maintenance director was educated by the Administrator on or before December 20th, 2016 on regulations regarding alarm annunciator for the EES.
K 916 Continued From page 15

Residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 38 on the date of the survey.

Findings include:

During the facility tour on November 17, 2016 from approximately 10:00 PM to 1:30 PM, observation of the alarm annunciator for the EES revealed that it was not operational. When asked, the Maintenance Supervisor stated that he was not aware the alarm annunciator was not working.

Actual NFPA standard:

NFPA 99
Chapter 3 Electrical Systems

3-4 Essential Electrical System Requirements - Type 1.
3-4.1.1.15 + Alarm Annunciator.
A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.)
The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:
(a) Individual visual signals shall indicate the following:
1. When the emergency or auxiliary power source is operating to supply power to load
2. When the battery charger is malfunctioning
(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:

| K 916 | 4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any potential nonoperational alarm annunciator for the EES. 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: 12/22/2016 |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 135105

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - ENTIRE NURSING FACILITY
B. WING ________________

(X3) DATE SURVEY COMPLETED 11/17/2016

NAME OF PROVIDER OR SUPPLIER

REXBURG CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

660 SOUTH SECOND STREET WEST
REXBURG, ID 83440

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

(X4) ID PREFIX TAG

K915 Continued From page 16

1. Low lubricating oil pressure
2. Low water temperature (below those
   required in 3-4.1.1.9)
3. Excessive water temperature
4. Low fuel - when the main fuel storage tank
   contains less than a 3-hour operating supply
5. Overcrank (failed to start)
6. Overspeed

Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually.

[110: 3-5.5.2]