March 20, 2017

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 8, 2017, 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
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 3, 2017**. Failure to submit an acceptable PoC by **April 3, 2017**, may result in the imposition of civil monetary penalties by **April 22, 2017**.

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 **April 12, 2017**, (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 12, 2017**. A change in the seriousness of the deficiencies on **April 12, 2017**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by
April 12, 2017, includes the following:

- Denial of payment for new admissions effective June 8, 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 September 8, 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 3; Fax #: (208) 364-1888, with
your written credible allegation of compliance. If you choose and so indicate, the PoC may
constitute your allegation of compliance. We may accept the written allegation of compliance
and presume compliance until substantiated by a revisit or other means. In such a case, neither
the CMS Regional Office nor the State Medicaid Agency will impose the previously
recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will
recommend that the remedies previously mentioned in this letter be imposed by the CMS
Regional Office or the State Medicaid Agency beginning on March 8, 2017, 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 April 3, 2017. If your request for informal dispute resolution is received after April 3, 2017, 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
Madison Carriage Cove Short Stay Rehabilitation is a single story, Type V(111) construction and is approximately 35,874 square feet in size. Plans were approved in May of 2013 and construction completed in July of 2014. The facility is fully sprinklered, with complete smoke detection and fire alarm system, is equipped with Type 2 Essential Electrical Service, piped medical gas and comprised of five smoke compartments.

The mechanical section on the partial second floor is separated and used for mechanical/data only. No storage or occupancy is allowed on the second floor. The attic space is abutting the mechanical/data area and is separated by one-hour, fire resistive construction. The facility is equipped with both fire and smoke dampers in fire-rated wall assemblies. The facility is currently licensed for 35 SNF/NF beds.

The following deficiencies were cited during the annual fire/life safety survey conducted on March 9, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.a

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

K 161
NFPA 101 Building Construction Type and Height
Building Construction Type and Height 2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7

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 the documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135140

A. BUILDING 02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION
B. WING

NAME OF PROVIDER OR SUPPLIER: MADISON CARRIAGE COVE SHORT STAY REHABILITATION
STREET ADDRESS, CITY, STATE, ZIP CODE: 410 WEST 1ST NORTH, REXBURG, ID 83440

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

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
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| K 161 continued From page 1 | 19.1.6.4, 19.1.6.5 Construction Type  
1. I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered  
2. II (111) non-sprinklered One story sprinklered  
3. II (000) non-sprinklered Not allowed  
4. III (211) sprinklered Maximum 2 stories  
5. IV (2H1)  
6. V (111)  
7. III (200) non-sprinklered Not allowed  
8. V (000) sprinklered Maximum 1 story  |

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, the facility failed to ensure the fire resistive properties of the structure were maintained in accordance with NFPA 101. Failure to seal penetrations in fire barriers could result in fires, smoke and dangerous gases passing through without proper containment.

K 161
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>K 161</td>
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<td>K 161</td>
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between compartments during a fire. This deficient practice affected staff and visitors of the upper level mechanical/data mezzanine on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 21 on the day of the survey.

Findings include:

During the facility tour conducted on March 9, 2017 from approximately 1:00 PM to 3:00 PM, observation of the one-hour fire wall separating the data room from the attic space revealed 1 of 5 approximately three (3) inch diameter conduits being utilized for data cabling, was not sealed to the attic, in accordance with the fire resistive rating of the wall. Further examination revealed airflow was clearly felt coming through this piping.

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.)

8.3.5 Penetrations. The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless
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<tr>
<td>K161</td>
<td>Continued From page 3 otherwise required by Chapters 11 through 43. 8.3.5.1* Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m²) between the exposed and the unexposed surface of the test assembly.</td>
<td>K161</td>
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<tr>
<td>K223</td>
<td>NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that doors equipped with self-closing devices were maintained in</td>
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### K223

Continued From page 4 accordance with NFPA 101. Failure of self-closing doors to operate as designed could allow smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 21 on the day of the survey.

Findings include:

During the facility tour conducted on March 5, 2017 from approximately 10:00 AM to 12:00 PM, observation and operational testing of doors in the facility revealed the following:

The door entering the main administrative offices was part of a one-hour fire rated assembly, with the door rated at forty-five (45) minutes. Further observation revealed the required self-closing device had been removed.

The door in the one-hour fire rated assembly entering the data room in the mechanical mezzanine was equipped to self-close, but would not fully close and latch when activated.

**Actual NFPA standard:**

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.

7.2.1.8 Self-Closing Devices:
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:** 135140

### Multiple Construction

- **A. Building 02 - Madison Carriage Cove Short Stay Rehabilitation**
- **B. Wing**

### Name of Provider or Supplier

**Madison Carriage Cove Short Stay REI**

**Street Address, City, State, ZIP Code:**

410 West 1st North, Rexburg, ID 83440

### Summary Statement of Deficiencies

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<tr>
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<tr>
<td>K 223</td>
<td>Continued From page 5</td>
<td>7.2.1.8.1 *A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3.</td>
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<tr>
<td>K 325</td>
<td></td>
<td>NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)</td>
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**ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:**

- Corridor is at least 6 feet wide
- Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols
- Dispensers shall have a minimum of 4-foot horizontal spacing
- Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
- Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30
- Dispensers are not installed within 1 inch of an ignition source
- Dispensers over carpeted floors are in sprinklered smoke compartments
- ABHR does not exceed 95 percent alcohol
- Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)
- ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485

This Standard is not met as evidenced by:

Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of automatic dispensing systems.
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<td>K 325</td>
<td>Continued From page 6 ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 21 residents, staff and visitors on the date of the survey. The facility is licensed for 35 SNF/NF residents and had a census of 21 on the day of the survey. Findings include: 1) During the review of facility inspection records conducted on March 9, 2017 from approximately 8:45 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refilling dispensers in accordance with manufacturer's care and use instructions. 2) During the facility tour conducted on March 9, 2017 from approximately 10:00 AM to 3:00 PM, observation of installed ABHR dispensers revealed automatic dispensers were installed in the main hallway and each resident room. When asked about refill testing and documentation, the Housekeeping staff stated he had not documented dispensers were tested each time a refill was installed. Actual NFPA standard: NFPA 101 19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</td>
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K 325 Continued From page 7

(2) The maximum individual dispenser fluid capacity shall be as follows:

(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors
(b) 0.53 gal (2.0 L) for dispensers in suites of rooms

(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.

(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).

(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).

(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).

(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.

(8) Dispensers shall not be installed in the following locations:

(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source

(b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source
K 325 Continued From page 8

source

(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source

(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.

(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.

(11) Operation of the dispenser shall comply with the following criteria:

(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.

(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.

(c) An object placed within the activation zone and left in place shall not cause more than one activation.

(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.

(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.

(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.

K 363

NFPA 101 Corridor - Doors

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
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<tr>
<td>K 363</td>
<td>Continued From page 9 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. 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 and interview, the facility failed to ensure that corridor doors were not impeded to self-closing as designed. Doors which are impeded from closing could allow 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 35 SNF/NF beds and had a census of 21 on the day of the survey. Findings include:</td>
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**Findings include:**
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:**
MADISON CARRIAGE COVE SHORT STAY REHABILITATION

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
410 WEST 1ST NORTH
REXBURG, ID 83440

**PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**
135140

**MULTIPLE CONSTRUCTION**
A. BUILDING 02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION
B. WING

**DATE SURVEY COMPLETED:**
03/08/2017

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<tr>
<td>K 363</td>
<td></td>
<td>Continued From page 10 During the facility tour conducted on March 9, 2017 from approximately 10:00 AM to 12:00 PM, observation of the door from the airborne isolation room (Room 222) to the corridor, revealed the door was impeded from self-closing by a metal wedge. When asked why the door was held open in this fashion, the care staff at the Nurse's station in the 200 hall stated the resident was not an airborne isolation risk. Actual NFPA standard: 19.3.6.3* Corridor Doors, 19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. 19.3.6.3.10* Doors shall not be held open by devices other than those that release when the door is pushed or pulled.</td>
<td>K 363</td>
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<tr>
<td>K 374</td>
<td>SS=F</td>
<td>NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or</td>
<td>K 374</td>
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<td>K374</td>
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|               | automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure the smoke resistive properties of smoke barrier doors. Failure to maintain smoke barrier doors could allow smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected 10 residents, staff and visitors on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 21 on the day of the survey. Findings include: During the facility tour conducted on March 9, 2017 from approximately 10:00 AM to 10:30 AM, observation of the smoke barrier doors located in the 100 hall revealed the northeast leaf was missing approximately 1/2 inch of the smoke gasket at the bottom of the leading edge of the door, leaving a gap approximately 1/2 inch by 1/2 inch between the doors when closed. Actual NFPA standard: 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and 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. 8.5.4.2 Where required by Chapters 11 through

| K374          |                                  |                              |                 |

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*Actual NFPA standard: 19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and 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.
4. Where required by Chapters 11 through.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135140

<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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</thead>
<tbody>
<tr>
<td>K 374</td>
<td>Continued From page 12</td>
<td></td>
<td>43, doors in smoke barriers that are required to be smoke leakage-rated shall comply with the requirements of 8.2.2.4.</td>
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<td>8.2.2.4 Where door assemblies are required elsewhere in this Code to be smoke leakage-rated in accordance with 8.2.2.4, door assemblies shall comply with all of the following:</td>
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<td>(1) They shall be tested in accordance with ANSI/UL 1784, Standard for Air Leakage Tests for Door Assemblies.</td>
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<td>(2) The maximum air leakage rate of the door assembly shall be 3.0 ft³/min/ft² (0.9 m³/min/m²) of door opening at 0.10 in. water column (25 N/m²) for both the ambient and elevated temperature tests.</td>
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<td>(3) Door assemblies shall be installed in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</td>
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<td>(4) Door assemblies shall be inspected in accordance with 7.2.1.15.</td>
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</tbody>
</table>

**Date Survey Completed:** 03/08/2017

**Address:**
- **Street:** 410 West 1st North
- **City:** Rexburg
- **State:** ID
- **Zip Code:** 83440

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**Printed:** 03/16/2017

**Form Approved:**
- OMB NO. 0938-0391
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).

K161

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

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?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The penetrations of the one hour fire wall separating the data room from the attic space by the 3 inch conduit used for data cabling will be sealed by appropriate & approved methods. It has been determined that the best way this will be accomplished is through fire proof pillow insulation.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a visual check initially & at least semiannually after that to ensure that all wall penetrations are appropriately sealed.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least semiannually to ensure compliance.

When will the corrective actions be completed?

4/15/17

K223

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

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?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The door to the Business Office will be equipped with an appropriate self closing device. All other self closing doors will be checked by the maintenance director or designee to ensure that self closing doors are in compliance.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
The Maintenance Director or designee will perform random door checking at least quarterly to ensure that all doors remain in compliance with approved standards.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly for 1 year.

When will the corrective actions be completed?

4/15/17

K325

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

Specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

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?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.

The Alcohol based hand rub dispensers will be appropriately maintained and a tracking log will be established to ensure that the dispensers are working properly throughout the facility.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will monitor and perform quarterly checks to ensure that the dispensers are working properly. The tracking log will be maintained to verify compliance.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly for 1 year.

When will the corrective actions be completed?

4/30/17

K363

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

The 11 specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

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?

All current and future residents, staff, visitors, and vendors have the potential to be affected by the deficient practice.
All impediments to self-closing doors were removed. The maintenance director or designee will do regular checks to ensure that self closing doors are not impeded.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The Maintenance Director or designee will perform a check at least quarterly on self closing doors and document any issues found. When issues are found staff will be appropriately educated.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly for a year.

When will the corrective actions be completed?

4/30/17

K374

What corrective action(s) will be accomplished for those residents, staff, visitors or vendors found to be affected by the deficient practice?

The 10 specific residents, staff, visitors, or vendors were not identified as being affected by the deficient practice.

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?

All 10 current residents, staff, and visitors on the 100 hall have the potential to be affected.

What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

The smoke barrier doors located on the 100 hall will have the gaskets replaced. The maintenance director or designee will inspect all facility smoke barrier doors at least quarterly & take corrective measures if any issues are found.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur?

The Quality Improvement Committee will review the reports from the Maintenance Director or designee at least quarterly for 1 year to ensure compliance.

When will the corrective actions be completed?

4/30/17

[Signature]

[Administrator]

4-7-17