April 13, 2018

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 April 3, 2018, 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 **April 26, 2018**. Failure to submit an acceptable PoC by **April 26, 2018**, may result in the imposition of civil monetary penalties by **May 16, 2018**.

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 8, 2018**, (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 **May 8, 2018**. A change in the seriousness of the deficiencies on **May 8, 2018**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by May 8, 2018, includes the following:

Denial of payment for new admissions effective July 3, 2018.

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 October 3, 2018, 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 April 3, 2018, 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 26, 2018. If your request for informal dispute resolution is received after April 26, 2018, 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
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED
04/03/2018

NAME OF PROVIDER OR SUPPLIER
REXBURG CARE & REHABILITATION CENTER

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

(X4) ID PREFIX TAG
SS=F

(X5) COMPLETION DATE

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<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>E 000 Initial Comments</td>
<td>The facility is a single-story type V (111) construction built in 1988. The building is fully sprinklered with smoke detection in corridors and open spaces. There are multiple exits to grade. The facility is currently licensed for 119 beds, and had a census of 53 on the dates of the survey. The following deficiencies were cited during the Emergency Preparedness Survey conducted on April 2 and 3, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney, Health Facility Surveyor, Facility Fire Safety &amp; Construction.</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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1) As a facility we will have scheduled a full-scale community-based exercise on or before May 7, 2018 by our Administrator.

2) As a facility we will have scheduled a full-scale community-based exercise on or before May 7, 2018 by our Administrator.

3) The maintenance director and the administrator will be reeducated the requirement for each facility to participate no less than annually in a laboratory for the identification and correction of defects in the machinery and equipment used in the facility.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) 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

**E 001**

Continued From page 1

program that meets the requirements of this section, utilizing an all-hazards approach.

* [For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to establish and maintain a current, comprehensive Emergency Preparedness program which includes training and testing of the EP plan in accordance with 42 CFR 483.73. Failure to meet this standard has the potential to hinder facility response during an emergency which requires coordination and cooperation with local resources available. This deficient practice affected 53 residents, staff and visitors on the date of the survey.

**Findings include:**

On April 2 and 3, 2018, review of the provided EP plan, revealed the facility could not provide documentation that a full-scale community-based exercise had taken place. When asked, the Administrator and Maintenance Director stated the facility was currently working on collaborating with local emergency responders, and would be completing the exercise soon.

a. Refer to E 0039 as it relates to required annual exercises to test the emergency plan.

**CFR reference:**

42 CFR 483.73

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**E 001**

full-scale community-based exercise on or before 5/7/2018.

4) Results of the full-scale community-based exercise will be reported to the center Performance Improvement (PI) committee.

5) The Administrator shall be responsible for compliance.

Compliance Date: 5/7/2018

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**COMPLETION DATE**

04/03/2018
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<td>E 039</td>
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<td>EP Testing Requirements</td>
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<td>CFR(s): 483.73(d)(2)</td>
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<td>(2) Testing. The [facility, except for LTC facilities, RNHCls and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCls and OPOs] must do all of the following:</td>
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<td>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]</td>
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<td>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</td>
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<td>(ii) Conduct an additional exercise that may include, but is not limited to the following:</td>
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<td>(A) A second full-scale exercise that is community-based or individual, facility-based.</td>
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<td>(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</td>
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<td>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</td>
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1) As a facility we will have scheduled a full-scale community-based exercise on or before May 7, 2018 by our Administrator.

2) As a facility we will have scheduled a full-scale community-based exercise on or before May 7, 2018 by our Administrator.

3) The maintenance director and the administrator will be reeducated the requirement for each facility to participate no less than annually in a full-scale community-based exercise on or before 5/7/2018.

4) Results of the full-scale community-based exercise will be reported to the center Performance Improvement (PI) committee.

5) The Administrator shall be responsible for compliance.

Compliance Date: 5/7/2018
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

135105

**(X2) MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

04/03/2018

**(X3) DATE SURVEY COMPLETED**

**NAME OF PROVIDER OR SUPPLIER**

REXBURG CARE & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

660 SOUTH SECOND STREET WEST

REXBURG, ID 83440

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<td>E 039</td>
<td>Continued From page 3</td>
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"[For RNHCl's at §403.748 and OPOs at §486.360(d)(2) Testing. The RNHCl and OPO must conduct exercises to test the emergency plan. The RNHCl and OPO must do the following:

(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(ii) Analyze the RNHCl's and OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's and OPO's emergency plan, as needed.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to implement an EP testing program. Failure to test the EP plan, has the potential to hinder staff response during a disaster. This deficient practice affected 53 residents, staff and visitors on the date of the survey.

Findings Include:

Review of the facility EP plan on April 2 and 3, 2018 revealed a written EP testing program. However, there was no documentation that specific testing, to include an annual full-scale, community-based exercise on the EP plan had been conducted. When asked, the Administrator stated the facility had not yet participated in a full-scale exercise."
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**NAME OF PROVIDER OR SUPPLIER**

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**STREET ADDRESS, CITY, STATE, ZIP CODE**

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**DATE SURVEY COMPLETED**

04/03/2018

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Reference: 42 CFR 483.73 (d) (2)
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
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
04/03/2018

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)

K 000  INITIAL COMMENTS

The facility is a single story-type V (111) construction built in 1988. The building is fully sprinklered with smoke detection in corridors and open spaces. There are multiple exits to grade. The facility is currently licensed for 119 beds, and had a census of 53 on the dates of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on April 2 and 3, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Chapter 19, Existing Healthcare Occupancies, in accordance with 42 CFR 483.70, 42 CFR 483.80 and 42 CFR 483.65.

The survey was conducted by:
Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction

K 232  SS=F

Aisle, Corridor, or Ramp Width
CFR(s): NFPA 101

Aisle, Corridor or Ramp Width
2012 EXISTING
The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5, 19.2.3.4, 19.2.3.5

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to maintain corridor exit access free of obstructions. Failure to maintain exit access width

This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Rexburg Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statement, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.

K 232

1) The wall sconce light fixtures that project past the required 4 inches will be replaced with ones that meet the requirement. Our Maintenance Director will complete this task on or before May 7th, 2018.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other wall sconce light fixtures that project past the required 4 inches and replace them. This inspection will be

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

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.
K 232 Continued From page 1

In the path of travel, could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 53 residents, staff and visitors on the date of the survey.

Findings include:

During the facility tour on April 2, 2018, from approximately 3:00 PM to 6:00 PM, observation of the exit access corridors revealed wall sconce light fixtures that projected from the corridor wall 7-1/2 inches at a height of approximately 69 inches from the floor. These light fixtures were in every corridor throughout the facility, exceeding the 4 inches allowed by ADA Standards. When asked, the Maintenance Director stated the facility was unaware of the requirements for non-continuous projections in the corridor.

Actual NFPA Standard:

19.2.3.4* Any required aisle, corridor, or ramp shall be not less than 48 in. (1220 mm) in clear width where serving as means of egress from patient sleeping rooms, unless otherwise permitted by one of the following:

1) Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (1120 mm) in clear and unobstructed width.

2) Where corridor width is at least 6 ft (1830 mm), non-continuous projections not more than 6 in. (150 mm) from the corridor wall, above the handrail height, shall be permitted.

3) Exit access within a room or suite of rooms complying with the requirements of 19.2.5 shall be permitted.

4) The management director shall be reeducated by the administrator of the requirement for non-continuous projections in the corridor on or before 5/7/2018.

4) Monthly rounds will be performed by our Maintenance Director for three months to identify any other wall sconce light fixtures that project past the required 4 inches and replace 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: 5/7/2018
K 232 Continued From page 2

(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:
   (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm).
   (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.
   (c) The wheeled equipment is limited to the following:
       i. Equipment in use and carts in use
       ii. Medical emergency equipment not in use
       iii. Patient lift and transport equipment

(5) *Where the corridor width is at least 8 ft (2440 mm), projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met:
   (a) The fixed furniture is securely attached to the floor or to the wall.
   (b) The fixed furniture does not reduce the clear unobstructed corridor width to less than 6 ft (1830 mm), except as permitted by 19.2.3.4(2).
   (c) The fixed furniture is located only on one side of the corridor.
   (d) The fixed furniture is grouped such that each grouping does not exceed an area of 50 ft² (4.6 m²).
   (e) The fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 ft (3050 mm).
   (f) The fixed furniture is located so as not to obstruct access to building service and fire protection equipment.
   (g) Corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed
K 232 Continued From page 3

furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space.

(h) The smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8.

CMS Final Rule:

SECTIONS 18.2.3.4(2) AND 19.2.3.4(2)-CORRIDOR PROJECTIONS

This provision requires noncontinuous projections to be no more than 6 inches from the corridor wall. In addition to following the requirements of the LSC, health care facilities must comply with the requirements of the ADA, including the requirements for protruding objects. The 2010 Standards for Accessible Design (2010 Standards) generally limit the protrusion of wall-mounted objects into corridors to no more than 4 inches from the wall when the object's leading edge is located more than 27 inches, but not more than 80 inches, above the floor. See Sections 204.1 and 307 of the 2010 Standards, available at http://www.ada.gov/regs2010/2010ADAStructures/Guidance2010ADAStructures.htm [2] ("2010 Standards"). This requirement protects persons who are blind or have low vision from being injured by bumping into a protruding object that they cannot detect with a cane.

Although the LSC allows 6-inch projections, under the ADA, objects mounted above 27 inches and no more than 80 inches high can only protrude a maximum of 4 inches into the corridor beyond a detectable surface mounted less than 27 inches above the floor (except for certain handrails which may protrude up to 41/2""). See
## K 232

Continued From page 4

section 307 of the 2010 standards for requirements for handrails and post-mounted objects. CMS intends to provide technical assistance regarding strategies for how to avoid noncompliance with the ADA's protruding objects requirement, as well as how to modify non-compliant protruding objects.

### K 353

Sprinkler System - Maintenance and Testing

SS=F

1) The sprinkler heads in the chart room by resident room #221, dirty linen area of the laundry room, wheel chair wash room and oxygen transfilling room will be replaced on or before May 7th, 2018.

2) A facility wide inspection will be performed by our Maintenance Director to identify any other sprinkler heads with paint on them on or before May 7th, 2018.

3) The maintenance director was reeducated by the administrator on requirement of sprinkler heads being free from paint on or before 5/7/2018.

4) Monthly rounds will be performed by our Maintenance Director for the facility for three months to identify any sprinkler heads with paint on them and get them replaced.

The results of these rounds will be reported to the center Performance
### Summary Statement of Deficiencies

**K 353**

Continued from page 5 and visitors on the date of the survey.

Findings include:

Observation during the facility tour on April 2, 2018, from approximately 3:00 PM to 6:00 PM, revealed the following sprinkler heads had non-factory paint on them:
- Chart room by resident room #221
- Dirty linen area of the laundry room
- Wheel chair wash room
- Oxygen transfilling room

When asked, the Maintenance Director stated the facility was not aware that the sprinklers had been painted.

Actual NFPA standard:

**NFPA 25**

5.2.1 Sprinklers.
5.2.1.1* Sprinklers shall be inspected from the floor level annually.
5.2.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).
5.2.1.2 Any sprinkler that shows signs of any of the following shall be replaced:
   1. Leakage
   2. Corrosion
   3. Physical damage
   4. Loss of fluid in the glass bulb heat responsive element
   5. *Loading
   6. Painting unless painted by the sprinkler manufacturer

### Provider's Plan of Correction

**K 353**

Improvement (PI) committee for three months.

5) The Maintenance Director shall be responsible for compliance.

Compliance Date: 5/7/2018
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA Identification Number: 135105

(X4) ID PREFIX TAG
K 911 Continued From page 6
SS=F CFR(s): NFPA 101

Summary Statement of Deficiencies
(Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

K 911
Electrical Systems - Other
List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station. Failure to provide a remote stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice affected 53 residents, staff and visitors on the date of the survey.

Findings include:
During the facility tour conducted on April 2, 2018 from approximately 3:00 PM to 6:00 PM, a remote manual stop station for the EES generator could not be located. When asked, both the Maintenance Director and the Administrator stated the facility was not equipped with a remote stop station.

Actual NFPA standard:
NFPA 99
6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE)

Provider's Plan of Correction
(Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)

1) A remote manual stop station for the EES generator will be installed. This task will be completed on or before May 7th, 2018.
2) A remote manual stop station for the EES generator will be installed. This task will be completed on or before May 7th, 2018.
3) The maintenance director was educated by our Administrator on or before May 7th, 2018 on the requirement to have a remote manual stop station for the EES generator.
4) The maintenance director was educated by our Administrator on or before May 7th, 2018 on the requirement to have a remote manual stop station for the EES generator.
5) The Maintenance Director shall be responsible for compliance.

Compliance Date: 5/7/2018
<table>
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<th>ID</th>
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<th>ID</th>
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<th>(X5) COMPLETION DATE</th>
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