



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2125 6546

December 11, 2014

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 **December 3, 2014**, 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 and a similar State Form 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

Monte Jones, Administrator
December 11, 2014
Page 2 of 4

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 both Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 24, 2014**. Failure to submit an acceptable PoC by **December 24, 2014**, may result in the imposition of civil monetary penalties by **January 13, 2015**.

Your PoC must contain the following:

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 7, 2015**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **January 7, 2015**. A change in the seriousness of the deficiencies on **January 7, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 7, 2015**, includes the following:

Monte Jones, Administrator
December 11, 2014
Page 3 of 4

Denial of payment for new admissions effective **March 3, 2015**.
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 **June 3, 2015**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 3, 2014**, 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:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Monte Jones, Administrator
December 11, 2014
Page 4 of 4

Go to the middle of the page to Information Letters section and click on State and select the following:

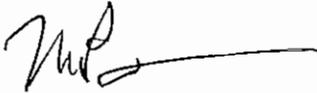
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 24, 2014**. If your request for informal dispute resolution is received after **December 24, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

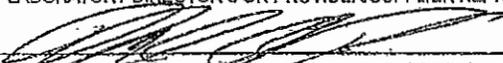
Printed: 12/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136106	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE-NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story type V(111) construction built in 1988. The building is fully sprinklered with smoke detection in corridors and open spaces. There are multiple exits to grade. The facility is currently licensed for 119 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on December 3, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	"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 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoke and fire resistive properties of the building. Failure to maintain smoke and fire resistance of the facility would allow smoke and fire to pass freely and grow beyond incipient stages during a fire event. This deficient practice affected residents, staff and visitors utilizing services provided in the 100 wing on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 42 on the day of the survey.	K 012	<u>K012</u> 1) The open penetrations in the walls in rooms 127, 129 and 132 exposing framing and insulation will be repaired on or before December 22, 2014 by our Maintenance Director. 2) A facility wide inspection will be performed by our Maintenance Director to identify and fix any other open penetrations on or before December 23, 2014. 3) The maintenance director was reeducated by the administrator on	

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

TITLE

(X6) DATE



Administrator

12-29-14

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.

* Revised - original submitted 12-22-14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: -135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 012	<p>Continued From page 1</p> <p>Findings include:</p> <p>During the facility tour conducted on December 3, 2014 from 11:30 AM to 3:30 PM, observation of the converted resident rooms 127, 129, 132 revealed missing drywall with exposed framing members and insulation in both the wall and ceiling systems. These open penetrations of the fire and smoke barrier varied in sizes from 12 inches by 12 inches to 24 inches by 24 inches.</p> <p>When asked, the Maintenance Supervisor stated that the missing drywall areas were due to a previous renovation project that had been ceased and repairs for leaks in both wall and ceiling areas. He further stated he was aware that these open penetrations were not allowed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 266, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.</p>	K 012	<p>open drywall penetrations on or before 12/23/2014.</p> <p>4) Monthly rounds will be performed by the Maintenance Director for three months to identify any potential open penetrations and fix them. The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 01/07/2015</p>	

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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		
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K 012	Continued From page 2 (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided	K 012		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6	K 018	<u>K018</u> 1) The corridor doors for rooms 206, 217 and 229 that failed to resist smoke based on the gap sizes when shut will either be adjusted to meet the requirement or will be repaired/replaced with new doors by a door vendor of our choice on or before January 7 th , 2015.	

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K 018	<p>Continued From page 3 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This Standard is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure that resident room doors would resist the passage of smoke. Failure of corridor doors to be smoke resistive would allow smoke and dangerous gases to pass freely between compartments affecting egress. This deficient practice affected 42 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 4, 2014 from 11:30 AM to 3:30 PM, observation and operational testing of the doors to resident rooms 206, 217 and 229 found they would not completely close and left a gap of approximately 3/4 inch at the strike side and up to 3/8" at the door head.</p> <p>Actual NFPA standard: 19.3.6.3 Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than</p>	K 018	<p>2) A facility wide inspection will be performed by our Maintenance Director to identify any other corridor doors that do not meet the requirement. The inspection will be completed on or before December 23rd, 2014.</p> <p>3) The maintenance director was reeducated by the administrator on corridor door open gap sizes requirements on or before 12/23/2014.</p> <p>4) Monthly rounds will be performed by our Maintenance Director for three months to identify any potential corridor doors that do not meet the requirement. The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 01/07/2015</p>	

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K 018	Continued From page 4 required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by:	K 029	<u>K029</u> 1) The corridor doors for rooms 124, 125, 126, 127, 128, 129, 130, 131, 132, 133 and Medical Records Office will be equipped with self-closing devices. Our Maintenance Director will choose the rooms that we will use for storage, condense if need be and only list rooms that will continue to be storerooms. Our Maintenance Director will complete this task on or before December 29 th , 2014.	

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K 029	<p>Continued From page 5</p> <p>Based on observation, operational testing and interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors on hazardous areas could allow smoke and dangerous gases to pass freely into corridors affecting safe egress. This deficient practice affected residents, staff and visitors utilizing services provided in the 100 wing on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on December 3, 2014 from 11:00 AM to 3:30 PM, observation of resident room doors in the 100 wing found the following rooms had been converted to storage and were over 100 square feet in size: 124, 125, 126, 127, 128, 129, 130, 131, 132, 133. Further examination of the doors to these rooms found them to be equipped with self-closing devices, but only room 127 and 129 would self-close when activated. Interview of the Maintenance Supervisor found he was aware of the storage and that the rooms were converted during a planned renovation.</p> <p>2) During the facility tour conducted on December 3, 2014 from 11:00 AM to 3:30 PM, observation of the Medical Records office in the 100 wing found it measured approximately 10 feet by 12 feet (120 sq. ft.). Further inspection found the door was not able to self-close. When asked, the Maintenance Supervisor stated he was not aware this door was required to self-close.</p> <p>Actual NFPA standard:</p>	K 029	<p>2) A facility wide inspection will be performed by our Maintenance Director to identify any other corridor doors that should be equipped with self-closing devices but do not. This inspection will be performed on or before December 23rd, 2014.</p> <p>3) The maintenance director was reeducated by the administrator on corridor door requirements to have self-closing devices on or before 12/23/2014.</p> <p>4) Monthly rounds will be performed by our Maintenance Director for three months to identify any potential corridor doors that do not meet the requirement.</p> <p>The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 01/07/2015</p>	

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K 029	<p>Continued From page 6</p> <p>NFPA 101 3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²). (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be 	K 029		

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K 029	Continued From page 7 permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that fire extinguishers were installed at the proper height per NFPA 10. Failure to install extinguishers at the correct height could hinder access during a fire event. This deficient practice affected 42 residents, staff and visitors on the date of the survey. The facility is licensed for 119 SNF/NF beds and had a census of 42 on the day of the survey. Findings include: During the facility tour conducted on December 3, 2014 from 11:00 AM to 3:30 PM, observation of the 10 lb fire extinguishers installed in the resident room corridors found that 9 of 10 were installed at a height of 68 inches to the top of the extinguisher. Further investigation of the Kitchen found a 20 lb ABC type extinguisher installed directly above the K-style extinguisher at a height of 64 inches to the top of the extinguisher. Interview of the Maintenance Supervisor found he was not aware of the height restriction of fire extinguisher installations.	K 064	K064 1) The 40lb fire extinguisher in the kitchen will be removed by our Maintenance Director on or before December 19 th , 2014. Our plan to meet the requirement is to hang the 9 fire extinguishers outside the fire extinguisher cabinets so that they meet the height requirement of 60" on or before January 7 th , 2015. 2) A facility wide inspection will be performed by our Maintenance Director to identify any other fire extinguishers that do not meet the height requirement. This inspection will be performed on or before January 7 th , 2015. 3) The maintenance director was reeducated by the administrator on fire extinguisher height requirements on or before January 7 th , 2015. 4) Monthly rounds will be performed by our Maintenance Director for the facility and kitchen for three months to identify any potential fire extinguisher issues that do not meet the requirements.	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135106	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NURSING FACILITY B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2014
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	<p>Continued From page 9</p> <p>During the facility tour conducted on December 4, 2014 from 11:30 AM to 3:30 PM, observation and operational testing of the door leading to the marked exit path through the maintenance/service corridor, was locked by an electromagnetic device. Special knowledge of the keypad code was required to exit. A second, similar device was observed on the exterior exit door, again preventing egress without special knowledge.</p> <p>When asked about this egress arrangement, the Maintenance Supervisor stated the first door locking assembly was installed to prevent residents or visitors from entering into the Maintenance corridor in error, but he acknowledged the signs installed clearly indicated it as an exit. He further stated the second locking arrangement to the exit discharge was to prevent unauthorized entry into the building, but was not sure why it was installed on the interior.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through</p>	K 072	<p>3) The maintenance director was educated by our regional property manager on or before December 23rd, 2014 on the life safety code for emergency egresses.</p> <p>4) Beginning the week of December 29th, 2014 the maintenance director or designee will conduct monthly inspections of the emergency exits. The results will be reported to the PI committee for 3 months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 01/07/2015</p>	

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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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 10 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 072		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations in accordance with NFPA 70. Failure to install and maintain electrical installations could result in electrocution and fire. This deficient practice affected residents, staff and visitors utilizing services provided in the 100 wing on the date of	K 147	<u>K147</u> 1) The open electrical connections and exposed wiring in rooms 125, 126, 127, 128, 129, 131, 132 and 133 will be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Our Maintenance Director will be	

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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		
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K 147	<p>Continued From page 11 the survey. The facility is licensed for 119 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on December 4, 2014 from 11:30 AM to 3:30 PM, observation of resident rooms in the 100 wing found open electrical installations in the following rooms: 125, 126, 127, 128, 129, 131, 132, 133. These installations included open three inch round abandoned light fixtures; two inch by four inch open outlet boxes; fluorescent light fixtures without the wire junction covers and an open packaged terminal air conditioning (PTAC) unit. The number of open electrical connections varied from 1- 5 in quantity per room.</p> <p>When asked about the substantial amount of open electrical connections and exposed wiring, the Maintenance Supervisor stated it was due to an abandoned renovation project for this wing and that he was aware that open electrical connections were prohibited.</p> <p>Actual NFPA standard:</p> <p>NFPA 70 Chapter 3 Wiring Methods and Materials ARTICLE 300 Wiring Methods</p> <p>314.28 Pull and Junction Boxes and Conduit Bodies. Boxes and conduit bodies used as pull or junction boxes shall comply with 314.28(A) through (D). Exception: Terminal housings supplied with motors shall comply with the provisions of 430.12.</p> <p>(C) Covers. All pull boxes, junction boxes, and</p>	K 147	<p>complete this work on or before 12/30/2014.</p> <p>2) A facility wide inspection will be performed by our Maintenance Director to identify and cover any other open electrical connections and exposed wiring. The inspection will be completed on or before 12/23/2014.</p> <p>3) The maintenance director was educated by the regional property manager on or before December 23rd, 2014 on regulations regarding open electrical connections.</p> <p>4) Monthly rounds will be performed by our Maintenance Director for three months to identify any open electrical connections and exposed wiring. The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p>5) The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 01/07/2015</p>	

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NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 860 SOUTH SECOND STREET WEST REXBURG, ID 83440		
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K 147	<p>Continued From page 12</p> <p>conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of 250.110. An extension from the cover of an exposed box shall comply with 314.22, Exception.</p> <p>Chapter 4 Equipment for General Use ARTICLE 406 Receptacles, Cord Connectors, and Attachment Plugs (Caps)</p> <p>406.1 Scope. This article covers the rating, type, and installation of receptacles, cord connectors, and attachment plugs (cord caps).</p> <p>406.5 Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface.</p> <p>ARTICLE 410 Luminaires (Lighting Fixtures), Lampholders, and Lamps</p> <p>410.3 Live Parts. Luminaires (fixtures), lampholders, and lamps shall have no live parts normally exposed to contact. Exposed accessible terminals in lampholders and switches shall not be installed in metal luminaire (fixture) canopies or in open bases of portable table or floor lamps. Exception: Cleat-type lampholders located at least 2.5 m (8 ft) above the floor shall be permitted to have exposed terminals.</p>	K 147		

Bureau of Facility Standards

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C 000	16.03.02 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. The following deficiencies were cited during the annual fire/life safety survey conducted on December 3, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY 106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities. This Rule is not met as evidenced by: Please refer to "K" tags on federal CMS 2567: K 012 Building construction K 018 Corridor doors K 029 Hazardous Area	C 226	<u>C226</u> Please refer to POC for K012 <u>C226</u> Please refer to POC for K018 <u>C226</u> Please refer to POC for K029 <u>C226</u> Please refer to POC for K064	

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

021100

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If continuation sheet 1 of 2

* Revised - original submitted 12-22-14

Administrative

12-29-14

Bureau of Facility Standards

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C 228	Continued From Page 1 K 064 Extingulsher installation K 072 Means of Egress K 147 Electrical Installations	C 228	<u>C226</u> Please refer to POC for K072 <u>C226</u> Please refer to POC for K147	

Idaho form

STATE FORM

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If continuation sheet 2 of 2