



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

.BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

April 1, 2019

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 **March 20, 2019**, 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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 15, 2019**. Failure to submit an acceptable PoC by **April 15, 2019**, may result in the imposition of civil monetary penalties by **May 6, 2019**.

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 **April 24, 2019**, (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 **June 18, 2019**. A change in the seriousness of the deficiencies on **May 4, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 24, 2019**, includes the following:

Denial of payment for new admissions effective **June 20, 2019**.  
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 20, 2019**, 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 20, 2019**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

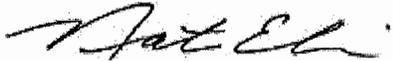
BFS Letters (06/30/11)

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

This request must be received by **April 15, 2019**. If your request for informal dispute resolution is received after **April 15, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - ENTIRE NURSING FACILITY</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/20/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>REXBURG CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>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. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. There are multiple exits to grade equipped with delayed egress devices. The facility is currently licensed for 119 beds and had a census of 42 on the dates of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on March 19 - 20, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Rexburg Care &amp; Rehabilitation Center</b> 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."</p>	
K 161 SS=D	<p><b>Building Construction Type and Height</b> CFR(s): NFPA 101</p> <p><b>Building Construction Type and Height</b> 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 19.1.6.4, 19.1.6.5</p> <p><b>Construction Type</b> 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p>	K 161	<p><b>K161</b></p> <p>1) The facility will repair the revealed drywall along the bottom of the wall in the mechanical/sprinkler riser room.</p> <p>2) An inspection will be performed to identify any additional wall penetrations in the facility. Any findings will be repaired.</p>	<p><b>RECEIVED</b> <b>APR 11 2019</b> <b>FACILITY STANDARDS</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>4-10-19</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  <b>REXBURG CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>	
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K 161	Continued From page 1  2 II (111) One story non-sprinklered sprinklered Maximum 3 stories  3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111)  7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to maintain rated construction assemblies, has the potential to allow fire, smoke and dangerous gases to pass into unprotected concealed spaces and between compartments. This deficient practice had the potential to affect staff and visitors in the utility hallway on the dates of the survey.	K 161	<b>3)</b> The Maintenance Director will be reeducated on the requirement for the facility to be free from wall penetrations.  <b>4)</b> The facility will do a monthly inspection of wall penetrations for 3 months. Any findings will be repaired.  Results of the monthly inspections will be reported to the center Performance Improvement (PI) committee.  <b>5)</b> The Maintenance Director shall be responsible for compliance.  Compliance Date: 4/22/2019	

**RECEIVED**  
**APR 11 2019**  
**FACILITY STANDARDS**

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K 161	Continued From page 2  Findings include:  During the facility tour conducted on March 20, 2019 from approximately 9:30 AM to 12:00 PM, observation of the mechanical/sprinkler riser room revealed the drywall along the bottom of one wall, abutting the floor, was damaged creating an approximately 8" x 8' penetration. When asked, the Maintenance Director stated the facility was aware of the penetration and had planned to repair it.  Actual NFPA standard:  19.1.6 Minimum Construction Requirements. 19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.) 8.2 Construction and Compartmentation. 8.2.1 Construction. 8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.	K 161		
K 222 SS=F	Egress Doors CFR(s): NFPA 101  Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING	K 222	<u><b>K222</b></u>  <b>1)</b> The facility will repair the two (2) exit doors in the activity area.  <b>2)</b> An initial inspection will be performed to identify any egress doors in the facility that do not meet the requirement.	

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K 222	<p>Continued From page 3</p> <p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b> Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p><b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b> Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p><b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b> Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be</p>	K 222	<p><b>3)</b> The Maintenance Director will be reeducated on the requirement for egress doors.</p> <p><b>4)</b> The facility will perform monthly testing of the egress doors for 3 months.</p> <p>Results of the testing will be reported to the center Performance Improvement (PI) committee.</p> <p><b>5)</b> The Administrator shall be responsible for compliance.</p> <p>Compliance Date: 4/22/2019</p>		

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

PRINTED: 03/29/2019  
FORM APPROVED  
OMB NO. 0938-0391

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K 222	<p>Continued From page 4 permitted. 18.2.2.2.4, 19.2.2.2.4 <b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b> Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure exit doors were arranged to be readily opened from the egress side. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency through a marked exit. This deficient practice affected 3 residents utilizing the activity area, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 20, 2019, from approximately 9:30 AM to 12:00 PM, observation of the two (2) exit doors in the activities area, revealed they were labeled as exits with delayed egress signage stating the magnetic locks would drop after 15 seconds. However, operational testing of the doors revealed the doors would not release after 15 seconds. The Maintenance Director stated the facility was not aware the doors were not functioning properly.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability.</p>	K 222		

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K 222	<p>Continued From page 5</p> <p>7.1.10.1* General. 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>7.2.1.6* Special Locking Arrangements.</p> <p>7.2.1.6.1 Delayed-Egress Locking Systems.</p> <p>7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:</p> <p>(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:</p> <p>(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6</p> <p>(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism.</p> <p>(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be</p>	K 222		

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K 222	Continued From page 6 continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1 7/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9.	K 222		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101  Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors	K 363	<b><u>K363</u></b>  1) The door for resident room #218 will be adjusted so that the gaps in the door meet the regulations.  2) A facility wide inspection will be performed by our Maintenance Director to identify any other doors that do not meet the requirements. Any doors found to be out of compliance will be adjusted.  3) The Maintenance Director will be reeducated by the Administrator of the requirement for gaps in doors.	

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K 363	<p>Continued From page 7</p> <p>complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 1 resident, staff, and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During the facility tour on March 20, 2019, from approximately 9:30 AM to 12:00 PM, observation and operational testing of the resident room doors revealed resident room #218 had an approximately 9/16" gap between the face of the</p>	K 363	<p><b>4)</b> Monthly rounds will be performed by our Maintenance Director for three months to identify any other 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><b>5)</b> The Maintenance Director shall be responsible for compliance.</p> <p>Compliance Date: 4/22/2019</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> - ENTIRE NURSING FACILITY  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>REXBURG CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>		
(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 363	Continued From page 8 door and the frame of the door when fully closed. When asked, the Maintenance Director stated the facility was unaware the door was out of compliance.  Actual NFPA Standards:  NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes	K 363			
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain safe electrical installations in	K 511	<b><u>K511</u></b>  <b>1)</b> The facility will install the missing blank in the 2K electrical panel in the kitchen. The facility will install the missing covers on two (2) electrical panels in the electrical room behind the janitorial closet in the 200 hallway. The facility will replace GFI outlets that would not reset in resident rooms #200 and #208. The facility will replace the zip style extension cords in resident room #216 and for the water softener in the mechanical/sprinkler riser room with compliant power strips.		

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K 511	<p>Continued From page 9 accordance with NFPA 70 and the equipment respective listing. Non-approved or listed modifications of electrical systems such as relocatable power taps (RPT's) and failure to cover open connections containing live parts, has the potential to expose residents to increased risks of electrocution and arc fires. This deficient practice affected 3 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour conducted on March 20, 2019 from approximately 9:30 AM - 12:00 PM, observation of the 2K electrical panel in the kitchen revealed it was missing a blank. Additionally, in the electrical room behind the janitorial closet in the 200 Hallway, two (2) electrical panels had their covers removed, exposing the interior of the panel and live wiring.</p> <p>2.) During the facility tour conducted on March 20, 2019 from approximately 9:30 AM - 12:00 PM, observation of electrical installations in the facility revealed the following:</p> <p>a.) GFI outlets in resident room bathrooms, revealed rooms #200 and #208 had GFI's that would not reset.</p> <p>b.) Resident room #216 had a zip style extension cord in use.</p> <p>c.) Water softener in the mechanical/sprinkler riser room was plugged in to a zip style extension cord.</p> <p>When asked about these deficiencies, the Maintenance Director stated the facility was not aware of them prior to the dates of this survey.</p>	K 511	<p><b>2)</b> A facility wide inspection will be performed by our Maintenance Director to identify any other missing blanks in electrical panels, missing covers for electrical panels, GFI outlets that will not reset and zip style extension cords that need to be replaced.</p> <p><b>3)</b> The Maintenance Director will be reeducated by the administrator on the requirement of not having blanks in electrical panels, having covers on electrical panels, having GFI outlets that will reset, not having any zip style extension cords in the facility.</p> <p><b>4)</b> Monthly rounds will be performed by our Maintenance Director of the facility for three months to identify any missing blanks in electrical panels, missing covers for electrical panels, GFI outlets that will not reset and zip style extension cords that need to be replaced.</p> <p>The results of these rounds will be reported to the center Performance Improvement (PI) committee for three months.</p> <p><b>5)</b> The Maintenance Director shall be responsible for compliance.</p>	

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  03/20/2019	
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K 511	<p>Continued From page 10 Actual NFPA standard:  NFPA 70</p> <p>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</p> <p>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</p> <p>110.3 Examination, Identification, Installation, and Use of Equipment. (A) Examination. In judging equipment, considerations such as the following shall be evaluated: (1) Suitability for installation and use in conformity with the provisions of this Code Informational Note: Suitability of equipment use may be identified by a description marked on or provided with a product to identify the suitability of the product for a specific purpose, environment, or application. Special conditions of use or other limitations and other pertinent information may be marked on the equipment, included in the product instructions, or included in the appropriate listing and labeling information. Suitability of equipment may be evidenced by listing or labeling. (2) Mechanical strength and durability, including, for parts designed to enclose and protect other equipment, the adequacy of the protection thus provided (3) Wire-bending and connection space (4) Electrical insulation (5) Heating effects under normal conditions of</p>	K 511	Compliance Date: 4/22/2019	

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K 511	<p>Continued From page 11</p> <p>use and also under abnormal conditions likely to arise in service</p> <p>(6) Arcing effects</p> <p>(7) Classification by type, size, voltage, current capacity, and specific use</p> <p>(8) Other factors that contribute to the practical safeguarding of persons using or likely to come in contact with the equipment</p> <p>(B) Installation and Use. Listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling.</p> <p>110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner.</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as</p>	K 511		



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K 712	Continued From page 13 Maintenance Director stated he was new to the facility, filling in on a temporary basis, and was unaware the fire drills were not completed during the fourth quarter of 2018.  Actual NFPA standard:  19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.	K 712			
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101  Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	K 914	<b><u>K914</u></b>  <b>1)</b> An annual test of the outlets in the resident rooms will be performed by the Maintenance Director.  <b>2)</b> An annual test of the outlets in the resident rooms will be performed by the Maintenance Director.  <b>3)</b> The Maintenance Director will be reeducated by the Administrator on the requirement to perform an annual test of the outlets in the resident rooms.  <b>4)</b> The annual test will be reviewed by the Administrator.  The results of this review will be reported to the center Performance Improvement (PI) committee.		

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K 914	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure outlets in resident care areas were maintained and tested. Failure to perform maintenance and testing on electrical systems has the potential of electrical outlet failure, exposing residents to the risks of arc fires. This deficient practice affected 42 residents staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>During review of facility maintenance and inspection records provided on March 19, 2019, from approximately 8:00 AM - 3:00 PM, the facility was unable to produce documentation to show outlets in resident rooms are tested annually. During the facility tour on March 20, 2019, from approximately 9:30 AM - 12:00 PM, observation of the resident rooms revealed electrical outlets were located near the beds. When asked, the Maintenance Director and Administrator stated the facility was not aware annual testing and documentation was required for outlets in resident rooms.</p> <p>Actual NFPA standard:</p> <p>NFPA 99 6.3.4.1 Maintenance and Testing of Electrical Systems 6.3.4.1.1 Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device.</p>	K 914	<p>5) The Administrator shall be responsible for compliance.</p> <p>Compliance Date: 4/22/2019</p>		

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K 914	Continued From page 15 6.3.4.1.2 Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914	<b><u>K918</u></b>	
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918	<p><b>1)</b> The facility will perform a monthly load test on the generator moving forward. The facility will perform a weekly generator inspection moving forward.</p> <p><b>2)</b> The facility will perform a monthly load test on the generator moving forward. The facility will perform a weekly generator inspection moving forward.</p> <p><b>3)</b> The Maintenance Director was reeducated by the Administrator on the requirement to perform a monthly load test on the generator and a weekly inspection of the generator.</p> <p><b>4)</b> The Administrator will perform a review of the documentation of the weekly inspection of the generator and the monthly load test for the generator, weekly for 4 weeks then monthly for 2 months.</p>	

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K 918	<p>Continued From page 16</p> <p>circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance with NFPA 110. Failure to inspect and test generators, could hinder the performance of the equipment during an emergency. This deficient practice affected 42 residents, staff and visitors on the dates of the survey.</p> <p>Findings include:</p> <p>Review of the facility generator inspection and testing records on March 19, 2019, from approximately 8:00 AM to 3:00 PM, revealed the facility had not performed a monthly load test in October 2018 and failed to provide the following weekly generator inspection logs:</p> <p>August 19, 2018 - August 25, 2018, September 2, 2018 - September 8, 2018, September 9, 2018 - September 15, 2018, September 23, 2018 - September 29, 2018, October 14, 2018 - October 20, 2018, December 2, 2018 - December 8, 2018, December 9, 2018 - December 15, 2018</p> <p>When asked, the Maintenance Director stated there had been several different Maintenance Directors over the past year, and the generator testing may have been overlooked during transitional periods.</p>	K 918	<p>The results of these reviews will be reported to the center Performance Improvement (PI) committee.</p> <p><b>5)</b> The Administrator shall be responsible for compliance.</p> <p>Compliance Date: 4/22/2019</p>	

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

PRINTED: 03/29/2019  
FORM APPROVED  
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  03/20/2019
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K 918	Continued From page 17  Actual NFPA standard:  NFPA 110 8.4 Operational Inspection and Testing. 8.4.1* EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating	K 918		



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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

April 1, 2019

Monte Jones, Administrator  
Rexburg Care & Rehabilitation Center  
660 South Second Street West  
Rexburg, ID 83440-2300

Provider #: 135105

**RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Jones:

On **March 20, 2019**, an Emergency Preparedness survey was conducted at Rexburg Care & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in black ink that reads "Nate Elkins". The signature is fluid and cursive.

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

PRINTED: 03/29/2019  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/20/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>REXBURG CARE &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SOUTH SECOND STREET WEST REXBURG, ID 83440</b>		
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E 000	<p>Initial Comments</p> <p>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. The Essential Electrical System is supplied by a diesel powered, on-site automatic generator. There are multiple exits to grade equipped with delayed egress devices. The facility is currently licensed for 119 beds and had a census of 42 on the dates of the survey.</p> <p>The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on March 19 - 20, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction</p>	E 000			

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

TITLE

(X6) DATE

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.