



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 17, 2019

Landon Taylor, Administrator  
Madison Carriage Cove Short Stay Rehabilitation  
410 West 1st North  
Rexburg, ID 83440-1406

Provider #: 135140

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER**

Dear Mr. Taylor:

On **April 10, 2019**, a Facility Fire Safety and Construction survey was conducted at Madison Carriage Cove Short Stay Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare 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. 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,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

Printed: 04/16/2019  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |   |
|---|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135140</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02 - MADISON CARRIAGE COVE SHORT STAY REHABILITATION</b><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>04/10/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>MADISON CARRIAGE COVE SHORT STAY REI</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>410 WEST 1ST NORTH<br/>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 000   | <p><b>INITIAL COMMENTS</b></p> <p>The facility is a single story, Type V(111) structure, approximately 35,874 square feet in size, originally constructed in 2014. There is a separated mechanical loft on the partial second floor. The facility is fully sprinklered, with complete smoke detection and fire alarm system. There is a Type 2 Essential Electrical Service, piped medical gas system and is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies. Currently the facility is licensed for 35 SNF/NF beds, with a census of 33 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on April 10, 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>Sam Burbank<br/>Health Facility Surveyor<br/>Facility Fire Safety &amp; Construction</p> | K 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.



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 17, 2019

Landon Taylor, Administrator  
Madison Carriage Cove Short Stay Rehabilitation  
410 West 1st North  
Rexburg, ID 83440-1406

Provider #: 135140

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

Dear Mr. Taylor:

On **April 10, 2019**, an Emergency Preparedness survey was conducted at Madison Carriage Cove Short Stay Rehabilitation 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,

Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosure

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

Printed: 04/16/2019  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |   |   |
|---|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135140</b>                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>04/10/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>MADISON CARRIAGE COVE SHORT STAY REI</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>410 WEST 1ST NORTH<br/>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                                |
| E 000   | <p>Initial Comments</p> <p>The facility is a single story, Type V(111) construction, approximately 35,874 square feet in size originally constructed in 2014. The building is located within a municipal fire district, with both county and state EMS services available. The structure is comprised of five smoke compartments, with both fire and smoke dampers in fire-rated wall assemblies.</p> <p>There is a separated, protected mechanical loft on the partial second floor. The facility is fully sprinklered, with a complete, interconnected smoke detection and fire alarm system. There is a Type 2 Essential Electrical Service which provides emergency power and piped medical gas system. Currently the facility is licensed for 35 SNF/NF beds with a census of 33 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the emergency preparedness survey conducted on April 10, 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>Sam Burbank<br/>Health Facility Surveyor<br/>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.