



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

April 1, 2015

John Schulkins, Administrator
Kindred Nursing & Rehabilitation-- Canyon West
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

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

Dear Mr. Schulkins:

On **March 23, 2015**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing & Rehabilitation - Canyon West** 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 Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on

John Schulkins, Administrator
April 1, 2015
Page 2 of 4

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 **April 14, 2015**. Failure to submit an acceptable PoC by **April 14, 2015**, may result in the imposition of civil monetary penalties by **May 4, 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 **April 27, 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 **April 27, 2015**. A change in the seriousness of the deficiencies on **April 27, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 27, 2015**, includes the following:

John Schulkins, Administrator
April 1, 2015
Page 3 of 4

Denial of payment for new admissions effective **June 23, 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 **September 23, 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 **March 23, 2015**, 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>

John Schulkins, Administrator
April 1, 2015
Page 4 of 4

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

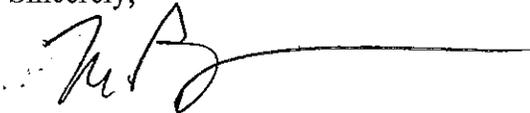
BFS Letters (06/30/11)

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

This request must be received by **April 14, 2015**. If your request for informal dispute resolution is received after **April 14, 2015**, 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,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
---	--

(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>INITIAL COMMENTS</p> <p>The facility is a single story structure of Type V(111) construction built in 1969. The building is protected throughout by an automatic fire sprinkler system with a fire alarm system that includes smoke detection in all corridors and open spaces. The facility is currently licensed for 103 beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on March 23, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy in accordance with 42 CFR 483.70.</p> <p>The survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000		
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility</p>	K 025	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation- Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	<p style="text-align: center;">RECEIVED APR 13 2015 FACILITY STANDARDS</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 4/14/2015
---	------------------------------------	-------------------------------

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.

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

Printed: 03/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 025	<p>Continued From page 1</p> <p>failed to ensure penetrations in smoke barrier walls were sealed. Failure to seal penetrations in smoke barriers would allow smoke and dangerous gases to pass between smoke compartments. This deficient practice affected 63 residents, staff and visitors in 3 of 4 smoke compartments on the date of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on March 23, 2015 from 1:15 PM to 3:30 PM, above the ceiling inspections of the smoke barrier walls at the main intersection of the 100, 200 and 300 wings found (5) unsealed penetrations in the smoke barrier located between room 302 and the Living room and (5) unsealed penetrations in the smoke barrier located between Administration and room 103. These penetrations ranged in size from 1/2" diameter to 3/4" diameter and were from new conduit and pipe installations and abandoned installations of pipes and conduits.</p> <p>When interviewed, the Maintenance Engineer stated he was not aware these penetrations had not been sealed.</p> <p>Actual NFPA standard:</p> <p>8.3 SMOKE BARRIERS</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those</p>	K 025	<p>K025 Corrective Action Penetrations were filled in the identified areas.</p> <p>Other Residents In addition the remainder of the building was inspected to identify other unsealed penetrations. None were found.</p> <p>Systematic Changes Penetrations caused by work by maintenance will be immediately filled. Contractors completing work will be requested to fill all penetrations made.</p> <p>Monitor The Executive Director or designee will randomly round within the center to ensure that no additional penetrations are noted.</p> <p>Date of Compliance April 27, 2015</p>	

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

Printed: 03/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 025	<p>Continued From page 2 found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p> <p>8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke</p>	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 025	Continued From page 3 barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This Standard is not met as evidenced by: 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 to hazardous areas would allow smoke and dangerous gases to pass freely into corridors, affecting egress during a fire event. This deficient practice affected 63 residents, staff and visitors on the date of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 63 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on March 23, 2015 from 10:45 AM to 12:30 PM, observation and operational testing of the doors to the Janitorial closet and Medical Records/Social Services office in the 300 wing found they would</p>	K 029	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation- Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>K029 Corrective Action Magnetic release mechanisms were installed on doors cited in Finding 1 and 2, except for Room 109. The medical records staged for destruction have been removed from that area.</p> <p>Other Residents In addition, the remainder of the building was reviewed for other areas requiring self-closing mechanisms on doors. None were found.</p> <p>Systematic Changes Areas with increased amount of combustible materials will be fitted with proper self-closing mechanisms on their doors.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 029	<p>Continued From page 4 not self-close.</p> <p>The Janitor closet measured approximately nine feet by six feet (54 square feet) and housed combustible materials of six bio-hazardous waste receptacles of approximately 32 gal. size, chemicals and cleaning supplies. Medical Records/Social Services office measured approximately ten feet by eight feet (80 square feet) and contained the primary medical and service records for the facility.</p> <p>2) During the facility tour conducted on March 23, 2015 from 1:15 PM to 3:30 PM, observation and operational testing of the doors to room 109, the Staff Development Coordinator's office and the Charting room abutting the reception station at the main entrance, found they would not self-close. Inspection of room 109 found it measured approximately ten feet by twelve feet (120 square feet) and had been converted to storage, containing stacks of boxed medical records for the facility being staged for destruction.</p> <p>Observation of the Charting room found it contained combustible paper, medical records and measured approximately ten feet by eight feet (80 square feet). Inspection of the Staff Development Coordinator's office found it measured approximately nine feet by eight feet and housed the stored records for inservice and staff development training.</p> <p>Interview of the Maintenance Engineer found he was not aware that the doors cited in Finding 1 and 2 were required to self-close.</p> <p>Actual NFPA standard: NFPA 101 2000 Edition</p>	K 029	<p>Monitor The Executive Director or designee will randomly round within the center to ensure that no combustible areas are noted.</p> <p>Date of Compliance April 27, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 029	<p>Continued From page 5</p> <p>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. <p>Exception: Doors in rated enclosures shall be</p>	K 029			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 062	<p>Continued From page 7 office</p> <p>Interview of the Maintenance Engineer found he was not aware of these painted heads.</p> <p>2) During the facility tour conducted on March 23, 2015 from 1:15 PM to 3:30 PM, observation of sprinkler heads in the 200 wing corridor found that (2) heads in the corridor ceiling were outside the same range as the adjacent heads. It was found that (1) head located between rooms 207/206 and (1) head located outside the med room were both rated for intermediate temperature response, while all others in the corridor were found to be rated for ordinary response, without a corresponding hazard change present.</p> <p>Interview of the Maintenance Engineer found he had never noticed the difference in the rated heads, but that some heads in the facility had been replaced due to issues involved with freezing and leaking pipes.</p> <p>Actual NFPA standard:</p> <p>Finding 1</p> <p>NFPA 25 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1*</p> <p>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in</p>	K 062	<p>K062</p> <p>Corrective Action Sprinkler heads identified in Findings 1 and 2 have been scheduled to be replaced by the contractor.</p> <p>Other Residents In addition the remainder of the building was inspected to identify other sprinkler heads out of compliance. None were found.</p> <p>Systematic Changes Replaced sprinkler heads will be monitored upon installation for proper type. Contractors will be informed prior to commencement of work of requirement.</p> <p>Monitor The Executive Director or designee will randomly round within the center to ensure that no inappropriate sprinkler heads are installed.</p> <p>Date of Compliance April 27, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 062	<p>Continued From page 8</p> <p>concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>Finding 2</p> <p>NFPA 25 2-4 Maintenance. 2-4.1 Sprinklers. 2-4.1.1*</p> <p>Replacement sprinklers shall have the proper characteristics for the application intended. These include the following:</p> <ul style="list-style-type: none"> (a) Style (b) Orifice size and K-factor (c) Temperature rating (d) Coating, if any (e) Deflector type (e.g., upright, pendant, sidewall) (f) Design requirements <p>Exception No. 1: Spray sprinklers shall be permitted to replace old-style sprinklers.</p> <p>Exception No. 2: Replacement sprinklers for piers and wharves shall comply with NFPA 307, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves.</p> <p>NFPA 13 3-2.5* Temperature Characteristics. 3-2.5.1</p> <p>The standard temperature ratings of automatic sprinklers are shown in Table 3-2.5.1. Automatic sprinklers shall have their frame arms colored in accordance with the color code designated in Table 3-2.5.1.</p> <p>Exception No. 1: A dot on the top of the deflector, the color of the coating material, or colored frame</p>	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 062	Continued From page 9 arms shall be permitted for color identification of corrosion-resistant sprinklers. Exception No. 2: Color identification shall not be required for ornamental sprinklers such as factory-plated or factory-painted sprinklers or for recessed, flush, or concealed sprinklers. Exception No. 3: The frame arms of bulb-type sprinklers shall not be required to be color coded.	K 062		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure that means of egress was not impeded. Failure to assure that egress capabilities are maintained free of obstructions or impediments could hinder egress during an emergency. This deficient practice affected 43 residents, staff and visitors on the day of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 63 on the day of the survey. Findings include: During the facility tour conducted on March 23, 2015 from 1:15 PM to 3:30 PM, observation and operational testing from the egress side of the following doors found they were non-single operational and required more than one action to release:	K 072	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kindred Nursing and Rehabilitation- Canyon West does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the center admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The center reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. K072 Corrective Action Locks were changed on all identified doors to comply with single operational requirement. Other Residents The remainder of the building was reviewed to ensure that no other multi-operational locks were in place. None were identified. Systematic Changes Prior to installation of new door opening mechanisms, the maintenance director will check to ensure that single operation requirement is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN		STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 10</p> <p>The three main entrance doors into the Kitchen were all equipped with both keyed entry locks and keyed deadbolts. The door into the pantry was equipped with a keyed entry lock and deadbolt. The door into the Administration office was equipped with a keyed entry lock and deadbolt. The three doors into the Laundry were equipped with passage locks and deadbolts. One of the deadbolts was dual-keyed, requiring a key from both sides to open. The Admissions office was equipped with a keyed entry lock and deadbolt. The Housekeeping storage was equipped with a keyed entry lock which required more than one operation to open from the egress side.</p> <p>When asked, the Maintenance Engineer stated he was not aware these locks were required to be single operational.</p> <p>Actual NFPA standard:</p> <p>7.1.10 Means of Egress Reliability. 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>7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one</p>	K 072	<p>Monitor The Executive Director or designee will randomly round within the center to ensure that no multi operation locks are installed.</p> <p>Date of Compliance April 27, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2015
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING & REHABILITATION - CAN			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(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 11 releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 072			