



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – 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

**REVISED COPY**

April 13, 2016

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

Provider #: 135051

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

Dear Mr. Schulkins:

On **April 8, 2016**, 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 one that comprises a pattern 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**

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completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 26, 2016**. Failure to submit an acceptable PoC by **April 26, 2016**, may result in the imposition of civil monetary penalties by **May 16, 2016**.

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 **May 13, 2016**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 13, 2016**. A change in the seriousness of the deficiencies on **May 13, 2016**, 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 **May 13, 2016**, includes the following:

Denial of payment for new admissions effective **July 8, 2016**.  
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 8, 2016**, 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 **April 8, 2016**, 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 **May 12, 2016**. If your request for informal dispute resolution is received after **May 12, 2016**, 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: 04/29/2016  
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  04/08/2016
NAME OF PROVIDER OR SUPPLIER  KINDRED NURSING & REHABILITATION - CANYON WEST			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	INITIAL COMMENTS  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.  The following deficiencies were cited during the annual Fire/Life Safety survey conducted on April 8, 2016. 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:  Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 012 SS=E	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 ensure that smoke partitions were maintained to limit the transfer of smoke. Failure to maintain smoke partitions could allow smoke and dangerous gases to pass freely through concealed spaces. This deficient practice affected 1 of 3 smoke compartments, 14 residents, staff and visitors on the date of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 50 on the day of the survey.	K 012	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.	

RECEIVED  
MAY - 6 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *John Schuler* TITLE *Executive Director* (X6) DATE *5/12/2016*

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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K 012	Continued From page 1  Findings include:  During the facility tour on April 8, 2016 at approximately 10:30 AM, observation of the Physical Therapy room revealed an approximate 2 inch by 4 inch in the ceiling. When asked, the Maintenance Supervisor stated the facility was not aware of the hole in the ceiling.  Actual NFPA standard:  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 256, 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. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.  8.2.4 Smoke Partitions. 8.2.4.1 Where required elsewhere in this Code, smoke partitions shall be provided to limit the transfer of smoke.	K 012	K012 <b>Corrective Action</b> The hole in the Physical Therapy room has been filled.  <b>Other Residents</b> In addition the remainder of the building was inspected to identify other compromises to the smoke partition. None were found.  <b>Systematic Changes</b> Holes in the ceiling caused by work by maintenance will be immediately filled. Contractors completing work will be requested to fill all holes made.  <b>Monitor</b> The Executive Director or designee will randomly round within the center to ensure that no additional compromises to smoke partitions are noted.  <b>Date of Compliance</b> May 13, 2016	

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K 012	Continued From page 2 8.2.4.2 Smoke partitions shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. Exception*: Smoke partitions shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where the following conditions are met: (a) The ceiling system forms a continuous membrane. (b) A smoketight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. (c) The space above the ceiling is not used as a plenum.	K 012		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility 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 2 of 3 smoke compartments, 36 residents, staff and visitors on the date of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 50 on the day of the survey.	K 025	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.  K025 <b>Corrective Action</b> Penetrations were filled in the identified area.	

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K 025	Continued From page 3  Findings include:  During the facility tour on April 8, 2016 at approximately 9:30 AM, observation of the smoke barrier wall above the false ceiling tiles in Unit 3 revealed an approximate 1 inch penetration passing through both sides of the smoke barrier wall that was unsealed. When asked, the Maintenance Engineer stated the facility was unaware of the unsealed penetration.  Actual NFPA standard:  19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.  8.3 SMOKE BARRIERS  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	K 025	<b>Other Residents</b> In addition the remainder of the building was inspected to identify other unsealed penetrations. None were found.  <b>Systematic Changes</b> Penetrations caused by work by maintenance will be immediately filled. Contractors completing work will be requested to fill all penetrations made.  <b>Monitor</b> The Executive Director or designee will randomly round within the center to ensure that no additional penetrations are noted.  <b>Date of Compliance</b> May 13, 2016		

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K 025	<p>Continued From page 4 thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>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:</p> <p>(1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(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:</p> <p>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibration</p>	K 025		

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K 025	Continued From page 5 into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	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><b>K038</b> <b>Corrective Action</b> The missing signage identifying delayed egress was replaced in the Tropicana Room, Paradise Room, and Employee Break Room doors.</p> <p><b>Other Residents</b> In addition, the remainder of the building was reviewed for other areas requiring self-delayed egress notification signage. None were found.</p> <p><b>Systematic Changes</b> All doors with installed delayed egress hardware will be equipped with proper notification signage.</p>	
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure delayed egress doors were properly marked with correct signage. Failure to provide proper signage on delayed egress doors could cause confusion and hinder evacuation of occupants in the facility. This deficient practice affected one of three smoke compartments, 6 residents, staff, and visitors on the date of survey. The facility is licensed for 103 SNF/NF beds with a census of 50 on the day of survey.</p> <p>Findings Include:</p> <p>1.) During the facility tour on April 8, 2016 at approximately 11:30 AM, observation of the delayed egress exit door located in the Tropicana room in Unit 2 revealed the door did not have a readily visible sign warning occupants that the door was equipped with delayed egress. When asked, the Maintenance Supervisor stated the facility was unaware the delayed egress sign was missing from the door.</p> <p>2.) During the facility tour on April 8, 2016 at approximately 11:30 AM, observation of the delayed egress exit door located in the Paradise</p>	K 038		

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K 038	<p>Continued From page 6</p> <p>room in Unit 2 revealed the door did not have a readily visible sign warning occupants that the door was equipped with delayed egress. When asked, the Maintenance Supervisor stated the facility was unaware the delayed egress sign was missing from the door.</p> <p>3.) During the facility tour on April 8, 2016 at approximately 11:40 AM, observation of the delayed egress exit door located in the break room in Unit 2 revealed the door did not have a readily visible sign warning occupants that the door was equipped with delayed egress. When asked, the Maintenance Supervisor stated the facility was unaware the delayed egress sign was missing from the door.</p> <p>Actual NFPA standard: 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1.6 Special Locking Arrangements. 7.2.1.6.1. Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors 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 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p>	K 038	<p><b>Monitor</b> The Executive Director or designee will randomly round within the center to ensure that proper signage is in place.</p> <p><b>Date of Compliance</b> May 13, 2016</p>	

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K 038	<p>Continued From page 7</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p>	K 038		