



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – 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

July 3, 2017

John Schulkins, Administrator
Kindred Nursing And Rehabilitation - Canyon West
2814 S. Indiana Ave.
Caldwell, ID 83605-5925

Provider #: 135051

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

Dear Mr. Schulkins:

On **June 22, 2017**, a Facility Fire Safety and Construction survey was conducted at **Kindred Nursing And 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. 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 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

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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 **July 17, 2017**. Failure to submit an acceptable PoC by **July 17, 2017**, may result in the imposition of civil monetary penalties by **August 5, 2017**.

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 will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 27, 2017**, (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 **July 27, 2017**. A change in the seriousness of the deficiencies on **July 27, 2017**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 27, 2017**, includes the following:

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Denial of payment for new admissions effective **September 22, 2017**.
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 **December 22, 2017**, 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 **June 22, 2017**, 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>

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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 **July 17, 2017**. If your request for informal dispute resolution is received after **July 17, 2017**, 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

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

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FORM APPROVED
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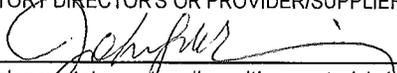
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2017
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - CANYON WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605
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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	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 life safety code survey conducted on June 22, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction NFPA 101 Building Construction Type and Height	K 000		
K 161 SS=D	Building Construction Type and Height 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 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered	K 161		

RECEIVED
JUL 17 2017
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director II	(X6) DATE 7/14/2017
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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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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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K 161	<p>Continued From page 1</p> <p>Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the smoke and fire resistive properties of the structure were maintained. Failure to maintain the fire resistive properties of the structure by sealing penetrations in walls and ceilings, could result in fire and smoke passing between compartments during a fire event. This deficient practice affected residents in the dining room, staff and visitors on the date of the survey. The facility is licensed for 103 SNF/NF beds and had a census of 56 on the day of the survey.</p> <p>Findings include:</p>	K 161	<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>

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K 161	<p>Continued From page 2</p> <p>During the facility tour on June 22, 2017, from approximately 12:00 AM to 3:00 PM, observation revealed the following penetrations:</p> <p>1.) The Housekeeping Closet next to the Laundry room had an approximately 6" x 8" hole in the wall.</p> <p>2.) The closet in the dish room portion of the kitchen had an approximately 5" x 10" hole in the wall.</p> <p>When asked, the Maintenance Supervisor stated the facility was not aware of the penetrations.</p> <p>Actual NFPA standard:</p> <p>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.</p>	K 161	<p>K161 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 July 17, 2017</p>	
K 325 SS=F	<p>NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)</p> <p>Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:</p> <ul style="list-style-type: none"> * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing 	K 325		

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K 325	<p>Continued From page 3</p> <ul style="list-style-type: none"> * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure Alcohol Based Hand Rub Dispensers (ABHR) were maintained. Failure to provide a program to test and document the operation of ABHR dispensers in accordance with the manufacturer's care and use instructions each time a new refill is installed could cause accidental spilling of flammable liquids or , increasing the risk of fire. This deficient practice affected 56 residents, staff and visitors on the date of the survey. The facility is licensed for 103 SNF/NF residents and had a census of 56 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility inspection records conducted on June 22, 2017 from approximately 8:30 AM to 11:00 AM, no records were available indicating ABHR dispensers are tested in accordance with manufacturer's care and use instructions when a new refill is installed. ABHR</p>	K 325		

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K 325	<p>Continued From page 4</p> <p>dispensers were observed throughout the entire facility. When asked, the Maintenance Supervisor stated the facility was not aware of the requirement to test ABHR dispensers each time a new refill is installed.</p> <p>Actual NFPA standard:</p> <p>NFPA 101</p> <p>19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:</p> <p>(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).</p> <p>(2) The maximum individual dispenser fluid capacity shall be as follows:</p> <p>(a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(b) 0.53 gal (2.0 L) for dispensers in suites of rooms</p> <p>(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.</p> <p>(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm).</p> <p>(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).</p>	K 325	<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>K325 Corrective Action The center has implemented a system to test ABHR dispensers each time a new refill is installed.</p> <p>Other Residents All residents were potentially impacted by the deficiency, and plan of correction applies to all ABHR dispensers within the center.</p> <p>Systematic Changes Staff that install ABHR dispenser refills have been trained on proper installation in accordance with manufacturer's care and use instructions. A log will be utilized to track proper installation and testing procedures. The maintenance director or designee will check the dispensers monthly to verify proper operation.</p>	

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K 325	<p>Continued From page 5</p> <p>(6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).</p> <p>(7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.</p> <p>(8) Dispensers shall not be installed in the following locations:</p> <p>(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source</p> <p>(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source</p> <p>(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source</p> <p>(9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.</p> <p>(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.</p> <p>(11) Operation of the dispenser shall comply with the following criteria:</p> <p>(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.</p> <p>(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.</p> <p>(c) An object placed within the activation zone and left in place shall not cause more than one activation.</p> <p>(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.</p>	K 325	<p>Monitor</p> <p>The Executive Director or designee will randomly round within the center to ensure that dispensers are operating correctly and will review the log to ensure proper tracking.</p> <p>Date of Compliance July 17, 2017</p>	

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K 374	<p>Continued From page 7</p> <p>During the facility tour on June 22, 2017, from approximately 12:00 AM to 3:00 PM, observation and operational testing of the two (2) double doors to the Dining Room, revealed the doors were not self-closing. Upon further observation of the doors when closed completely revealed a gap in between the doors that was measured to be approximately 1 inch when fully closed that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware the doors were required to resist the passage of smoke, or the need for the doors to be self-closing and on magnetic hold-open devices.</p> <p>Actual NFPA Standards:</p> <p>19.3.7.8* Doors in smoke barriers shall comply with 8.5.4 and all of the following: (1) The doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.7. (2) Latching hardware shall not be required (3) The doors shall not be required to swing in the direction of egress travel.</p> <p>8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3.4 in. (19 mm).</p> <p>8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions</p>	K 374	<p>Monitor The Executive Director or designee will randomly round within the center to ensure that smoke compartments have the proper self-closing mechanisms for doors.</p> <p>Date of Compliance July 17, 2017</p>	

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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 06/22/2017	
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND 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 374	Continued From page 8 of 7.2.1. 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the holdopen mechanism is released and the door leaf becomes self-closing. (5) The release by means of smoke detection of one door leaf in a stair enclosure results in closing all door leaves serving that stair.	K 374		
K 926 SS=D	NFPA 101 Gas Equipment - Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment.	K 926		

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

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K 926	<p>Continued From page 9</p> <p>11.5.2.1 (NFPA 99)</p> <p>This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide programs of continuing education for personnel who handle medical gases and the cylinders that contain the medical gases. Providing an educational program and periodic review will minimize or eliminate the displacement of oxygen from a leaking gas cylinder fires or injuries caused by flammable gas ignition, inhalation of a toxic or asphyxiating gas, or flying objects accelerated by an explosion or pressure released. This deficient practice could potentially affect the residents that are need of oxygen, staff and visitors on the date of the survey. The facility is licensed for 103 SNF/NF residents and had a census of 56 on the day of the survey.</p> <p>Findings include:</p> <p>During the review of facility training records conducted on June 22, 2017 from approximately 8:30 AM to 11:00 AM, no records were available indicating that the facility maintains an ongoing continuing education program for staff which includes periodic review of safety guidelines and usage requirements for medical gases and their cylinders. When asked, the Maintenance Supervisor stated the facility was not aware of the requirement for medical gas training.</p> <p>NFPA 101 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, Health Care Facilities Code, applicable to administration, maintenance, and testing.</p>	K 926	<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>	

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K 926	Continued From page 10 NFPA 99 11.5.2 Gases in Cylinders and Liquefied Gases in Containers. 11.5.2.1 Qualification and Training of Personnel. 11.5.2.1.1* Personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. 11.5.2.1.2 Health care facilities shall provide programs of continuing education for their personnel. 11.5.2.1.3 Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders.	K 926	K926 Corrective Action Staff have been educated regarding medical gasses and the cylinders that contain the medical gasses. <i>eg. SES, 7/3</i> Other Residents No residents were impacted by the finding. Systematic Changes Education included minimization or elimination of the displacement of oxygen from a leaking gas cylinder, fires or injuries caused by flammable gas ignition, inhalation of a toxic or asphyxiating gas, or flying objects accelerated by an explosion or related pressure. Continuing education on the topic will be offered to staff going forward. Monitor The Executive Director will periodically review in-service records to ensure that proper training is taking place. Date of Compliance July 17, 2017	