



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

September 16, 2015

Tamara Gillins, Administrator  
Syringa Chalet Nursing Facility  
PO Box 400  
Blackfoot, ID 83221-0400

Provider #: 135111

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

Dear Ms. Gillins:

On **September 10, 2015**, a Facility Fire Safety and Construction survey was conducted at **Syringa Chalet Nursing Facility** 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** completion date for each federal and state tag in column (X5) Completion Date to signify when

Tamara Gillins, Administrator  
September 16, 2015  
Page 2 of 4

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 **September 29, 2015**. Failure to submit an acceptable PoC by **September 29, 2015**, may result in the imposition of civil monetary penalties by **October 19, 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 **October 15, 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 **October 15, 2015**. A change in the seriousness of the deficiencies on **October 15, 2015**, may result in a change in the remedy.

Tamara Gillins, Administrator  
September 16, 2015  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **October 15, 2015**, includes the following:

Denial of payment for new admissions effective **December 10, 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 **March 10, 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 **September 10, 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:

Tamara Gillins, Administrator  
September 16, 2015  
Page 4 of 4

<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 **September 29, 2015**. If your request for informal dispute resolution is received after **September 29, 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,



Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

Printed: 09/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135111</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/10/2015</b>
NAME OF PROVIDER OR SUPPLIER <b>SYRINGA CHALET NURSING FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 EAST ALICE STREET BLACKFOOT, ID 83221</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	INITIAL COMMENTS  The facility is a four story type II (222) fire resistive building. Residents are currently being housed on the first and second level, the ground floor is ancillary services only and the fourth floor currently houses minimal staff. A complete fire sprinkler system was installed in June of 2012. The building was last renovated in 1996. There are multiple exits to grade and the facility fire alarm is monitored off site and at the on campus central security building. The building is licensed for 29 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on September 9, 2015 - September 10, 2015. 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 and Construction	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027		

RECEIVED  
SEP 29 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Tamara Gillins, NHA, LCSW* TITLE: *Administrator* (X6) DATE: *9/28/15*

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 029	<p>Continued From page 2</p> <p>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 doors that would resist the passage of smoke. Failure to provide doors that would resist the passage of smoke in hazardous areas would allow smoke and dangerous gases to pass freely into corridors during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 29 SNF/NF beds and had a census of 24 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 9, 2015 at approximately 4:00 PM, observation and operational testing of room 307 revealed the room was turned into storage and the door was not on a self-closure. It was observed the room was greater than 100 square feet and was housing bulk laundry and other combustible items. When asked, the Maintenance Supervisor stated the facility was unaware the door needed to be on a self closure.</p> <p>Actual NFPA standard: NFPA 101, 19.3.2.1 Hazardous Areas.</p>	K 029		

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K 029	Continued From page 3 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:  (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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.	K 029		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This Standard is not met as evidenced by: Based on observation, operational testing and	K 064	Work order 12787 was submitted to the Maintenance Department to order and install fire extinguisher sign on or above extinguisher cabinet.  Maintenance Department ordered a sign for this metal cabinet on September 18, 2015 and will be installed no later than October 2, 2015.  Maintenance Department will complete inspections on a bi-monthly basis to ensure that these remedies remain permanent.  Administrator to ensure checks are completed. Results reported at Quarterly QA/PI Meeting.	10/10/15

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K 064	<p>Continued From page 4</p> <p>interview, the facility failed to ensure that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers are readily accessible and conspicuously marked could inhibit their use during a fire event. This deficient practice affected residents using the chapel, staff and visitors on the date of the survey. The facility is licensed for 29 SNF/NF beds with a census of 24 on the day of the survey.</p> <p>Findings include:</p> <p>1). During the facility tour on September 9, 2015 at approximately 4:30 PM, observation of the Chapel revealed a fire extinguisher cabinet built of solid wood that was not conspicuously marked to identify the fire extinguisher location.</p> <p>2). During the facility tour on September 9, 2015 at approximate 3:45 PM, observation and operational testing of both fire extinguisher cabinets on the third floor revealed the cabinet handles were missing making the doors hard to open and the extinguishers not readily accessible and immediately available for operational use.</p> <p>When asked, the Safety Risk Manager stated the facility was unaware of the conspicuous marking requirement for the extinguisher cabinet in the Chapel but stated the facility was aware the extinguisher cabinet handles were missing.</p> <p>Actual NFPA standard: NFPA 10 Standard for Portable Fire Extinguishers 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal</p>	K 064	<p>Work order 12786 was submitted to the Maintenance Department to order and install pull handles on fire extinguisher cabinets.</p> <p>Maintenance Department installed handles on the two cabinets on September 11, 2015.</p> <p>Maintenance Department will complete inspections on a bi-monthly basis to ensure that these remedies remain permanent.</p> <p>Administrator to ensure checks are completed. Results reported at Quarterly QA/PI Meeting.</p>	9/11/15

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K 064	Continued From page 5 paths of travel, including exits from areas.	K 064		