



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

TAMARA PRISOCK--ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T -- Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0099
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 16, 2015

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

Provider #: 135111

Dear Ms. Gillins:

On **October 9, 2015**, a survey was conducted at Syringa Chalet Nursing Facility by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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/or 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. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.**

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

After each deficiency has been answered and dated, the administrator should sign the Form CMS-2567 and State Form (if applicable), Statement of Deficiencies and Plan of Correction in the spaces provided and return the original(s) to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 29, 2015**. Failure to submit an acceptable PoC by **October 29, 2015**, may result in the imposition of civil monetary penalties by **November 17, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report; State Form (if applicable).

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 **November 12, 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 **November 12, 2015**. A change in the seriousness of the deficiencies on **November 12, 2015**, may result in a change in the remedy.

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

The remedy, which will be recommended if substantial compliance has not been achieved by **November 12, 2015** includes the following:

Denial of payment for new admissions effective **January 9, 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 non-compliance, 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 **April 9, 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, CMS will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (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 **October 9, 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>

Tamara Gillins, Administrator
October 16, 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 **October 29, 2015**. If your request for informal dispute resolution is received after **October 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, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in cursive script, appearing to read "Nina Sanderson", written in black ink.

NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET (83221-4926) BLACKFOOT, ID 83221
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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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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Brad Perry, BSW, LSW</p> <p>The survey team entered the facility on October 5, 2015, and exited on October 9, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living BG = Blood Glucose BIMS = Brief Interview for Mental Status CAA = Care Area Assessment cm = Centimeters CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NE = Nurse Educator PRN = As Needed RAI = Resident Assessment Instrument</p>	F 000		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive</p>	F 279	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Care Plans for residents #1 and #6 have been updated to include urinary incontinence. Resident #2 discharged 10/27/2015.</p>	11/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Samara Hillins NHA, LCSW</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/28/15</i>
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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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F 279	<p>Continued From page 1 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a Urinary Incontinence, triggered by the RAI (Resident Assessment Instrument) process, was care planned as identified in the CAA (Care Area Assessment). This was true for 3 of 6 (#s 1, 2 & 6) residents sampled for the RAI process. This practice created the potential for harm due to lack of direction in resident care plans. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 8/30/05 and readmitted on 3/26/10 with diagnoses of vascular dementia, hypothyroidism and cerebral atherosclerosis.</p> <p>The 3/10/15 Annual MDS Assessment documented the resident's cognitive skills for daily decision making was assessed by staff as severely impaired; was frequently incontinent; and, was totally dependent on two+ staff members for toilet use and personal hygiene. The MDS, documented in Section V, the Urinary Incontinence Care Area would be care planned.</p>	F 279	<p>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: The Care Plans for all other residents with urinary incontinence have been reviewed and updated if needed to include urinary incontinence.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: With the completion of each Quarterly MDS, Comprehensive MDS with CAAs, or as a resident's status changes, a Care Plan will be developed, reviewed or revised as needed to ensure urinary incontinence is addressed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: MDS Coordinator will audit Care Plans weekly x 4 then q 2 weeks x 4, then monthly x 3 to ensure compliance. Results reported at quarterly QA/PI Meetings. Audits to start week of 11/2/15.</p>	
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F 279	<p>Continued From page 2</p> <p>The 3/10/15 CAA Worksheet, completed with the annual assessment documented in the Care Plan Considerations section the functional status would be addressed in the care plan.</p> <p>Record review of the resident's care plan did not provide evidence a care plan had been developed for urinary incontinence.</p> <p>On 10/9/15 the MDS Coordinator stated she thought she had care planned Resident #1's urinary incontinence, that she was totally incontinent and was changed every two hours. She stated, "I missed it."</p> <p>2. Resident #2 was admitted to the facility on 6/30/15 and on 7/21/15 with diagnoses of congestive heart failure, chronic kidney disease and major depressive disorder with psychotic behaviors.</p> <p>The 7/28/15 Annual MDS Assessment documented the resident was cognitively intact, and needed the assistance of one staff member for transfers and toilet use. The MDS documented in Section V the Urinary Incontinence Care Area would be care planned.</p> <p>The 7/28/15 CAA Worksheet, completed with the annual assessment, documented in the Care Plan Considerations section, the functional status would be addressed in the care plan.</p> <p>Record review of the resident's care plan did not provide evidence a care plan had been developed for urinary incontinence.</p> <p>On 10/9/15 the MDS Coordinator stated she</p>	F 279			

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F 279	Continued From page 3 could not find anything specific in the care plan regarding urinary incontinence and there should be a care plan for urinary incontinence. 3. Resident #6 was admitted to the facility on 4/22/13 and readmitted 9/25/14 with diagnoses of major depression, dementia, and hypothyroidism. The 8/25/15 Annual MDS Assessment documented the resident was cognitively intact, was totally dependent for transfers and needed the assistance of two+ staff members and extensive assistance of two+ staff members for toilet use and personal hygiene. The MDS documented in Section V, the Urinary Incontinence Care Area would be care planned. The 8/25/15 CAA Worksheet, completed with the annual assessment, documented in the Care Plan Considerations section, the functional status would be addressed in the care plan. Record review of the resident's care plan did not provide evidence a care plan had been developed for urinary incontinence. On 10/9/15 the MDS Coordinator stated she did not develop a care plan for urinary incontinence.	F 279		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 281	F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #2 discharged 10/27/2015. A new policy/procedure addressing delegation by Licensed Nursing to CNAs performing BG checks will be developed for Resident #7 and all other residents requiring BG checks.	11/12/15

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F 281	<p>Continued From page 4</p> <p>determined the facility failed to ensure professional standards of quality were maintained when a policy and procedure for delegation of blood glucose (BG) levels by LNs (Licensed Nurse) to CNAs was not developed. Failure to adhere to professional standards created the potential for harm should residents have inaccurate blood glucose readings and/or receive inaccurate doses of insulin. Findings included:</p> <p>The Idaho Administrative Code for the Board of Nursing documented under Section 400.01 Decision-Making Model, page 34, "The decision-making model is the process by which a licensed nurse evaluates whether a particular act is within the legal scope of that nurse's practice and determines whether to delegate the performance of a particular nursing task in a given setting. This model applies to all licensure categories permitting active practice, regardless of the setting...e. The employment setting/agency has established policies and procedures or job descriptions authorizing performance of the act. f. Performance of the act is within the accepted standard of care that would be provided in a similar situation by a reasonable and prudent nurse with similar education and experience and the nurse is prepared to accept the consequences of the act." Section 400.03, Monitoring Delegation, page 35, documented, "a. Evaluate the patient's response and the outcome of the delegated act, and take such further action as necessary; and, b. Determine the degree of supervision required and evaluate whether the activity is completed in a manner that meets acceptable outcomes. The degree of supervision shall be based upon the health status and stability of the patient, the complexity of the care and the knowledge and competence of the individual to</p>	F 281	<p>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:</p> <p>The policies regarding blood glucose monitoring have been updated to include the delegation of BG monitoring to CNA's and to clarify that it will be the responsibility of the licensed nurse delegating any portion of the task to verify competency of the designated staff before delegating and to ensure proper completion of the assignment. All CNA's currently trained to complete blood glucose monitoring will be observed and signed off for competency of blood glucose monitoring on a resident by a licensed nurse. This verification will be kept with the original training documentation. CNA's who are trained going forward will complete this process during orientation in addition to the training offered by the nurse educator in new employee orientation. A separate section will be added to the orientation checklist with a requirement for the overseeing licensed nurses' signature verifying competency.</p>	
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NOV 03 2015

FACILITY STANDARDS

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F 281	<p>Continued From page 5</p> <p>whom the activity is delegated." Section 490 Unlicensed Assistive Personnel (UAP), page 38, documented, "The term unlicensed assistive personnel also includes licensed or credentialed health care workers whose job responsibilities extend to health care services beyond their unusual and customary roles and which activities are provided under the direction and supervision of licensed nurses...02. Delegation. The nursing care tasks that may be delegated to unlicensed assistive personnel shall be stated in writing in the practice setting. Decisions concerning delegation will be determined in accordance with the provisions of Section 400."</p> <p>On 10/7/15, LN #5 stated she had delegated checking BG levels to CNA #4 for Resident #s 2 & 7. LN #5 stated the Nursing Educator (NE) had trained CNA #4 on BG Protocols and she had demonstrated proficiency to the NE. LN #5 stated she had not observed CNA #4 to do BG checks.</p> <p>On 10/7/15 at 11:40 AM, CNA #4 was observed as she checked BG levels for Resident #s 2 & 7. She stated she volunteered to perform BG checks but didn't like to do them because it heightened her stress level. CNA #4 stated she demonstrated to the NE she could perform the BG checks with control solution but a nurse had not actually observed her to do BG checks on a resident.</p> <p>On 10/7/15, the DNS provided copies of the policies and procedures for glucose monitoring, staff inservices, and quality control. Record review documented these policies were for licensed nurses. The DNS stated we have referenced licensed nurses to include CNA staff, but do not have policies and procedures specific</p>	F 281	<p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur:</p> <p>Going forward CNA's will be trained by the nurse educator in new employee orientation to complete blood glucose monitoring. They will then be observed and signed off for competency of blood glucose monitoring on a resident by a licensed nurse during orientation on the floor. A separate section will be added to the orientation checklist with a requirement for the overseeing licensed nurses' signature verifying competency.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place:</p> <p>The director of nursing services or designee will coordinate with the nursing educator to ensure that all CNA's who have been trained to this point have written verification by a licensed nurse of competency to perform blood glucose monitoring on a resident by 11-12-15. The nurse educator will verify new employees competency has been verified by a licensed nurse on the floor when checking completion of the orientation checklist. Results reported at quarterly QA/PI Meeting.</p>	
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F 281	Continued From page 6 to the delegation of CNA's performing BG checks.	F 281		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were free from unnecessary medications. This was true for 1 of 6 residents (#6) sampled for gradual dose reductions. This	F 329	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: PA to evaluate appropriateness of a GDR for Cymbalta and Seroquel for Resident #6 and provide rationale if contraindicated. 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: PA or designee to identify and evaluate all other residents taking antidepressant and/or antipsychotic drugs to ensure compliance with the GDR standards. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: PA evaluates the medication regimen for all residents upon admission and provides on-going evaluation and medication changes with any noted side effects or behavioral changes as appropriate. Additionally, PA will review all residents taking antipsychotic and/or antidepressant drugs at their quarterly MDS review to ensure compliance with the GDR regulations.	11/12/15

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F 329	<p>Continued From page 7</p> <p>created the potential for harm as unnecessary medications can lead to adverse reactions and health decline. Findings included:</p> <p>Resident #6 was admitted to the facility on 4/22/13 and readmitted 9/25/14 with diagnoses of major depression, dementia, and borderline personality disorder.</p> <p>Record review of the resident's September 2015 Pharmacy - Drug Regimen (recapitulation orders), documented the following orders: *Cymbalta, oral, give 60 mg every AM for depression, anxiety and chronic pain, with a start date of 1/16/15; *Seroquel XR (Extended Release) tablet, give 200 mg every AM for mood, impulsivity and anxiety, with a start date of 4/18/14; and, *Seroquel tablet, give 50 mg PO (per oral) every 6 hours PRN for anxiety. Not to exceed 2 as needed doses daily, with a start date of 4/17/14.</p> <p>On 10/9/15 at 10:05 AM, the DNS stated the resident was originally started on Cymbalta at 20 mg every AM on 1/11/14 and she was unable to find a gradual dose reduction. The DNS stated the resident was admitted to the facility on 4/22/13 with orders for Seroquel and did not have a gradual dose reduction for this last year. The DNS stated she had spoken to the PA (Physician Assistant) regarding the lack of gradual dose reductions for Cymbalta and Seroquel. The PA explained the process for gradual dose reductions was to set a repeating alert/reminder. She stated she had reset the alert after she adjusted the resident's order for another medication, and had forgotten to make a note to address other medications. She told the DNS she would not reset her alert until she had addressed</p>	F 329	<p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place:</p> <p>PA or designee to audit compliance with GDRs weekly x 4, then q 2 weeks x 4 then monthly x 3 with MDS reviews. Results reported at quarterly QA/PI Meeting. Audits to begin week of 11/9/15</p>		

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

PRINTED: 10/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET (83221-4925) BLACKFOOT, ID 83221
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F 329	Continued From page 8 all her medications in the future.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, Food Service Infection Control policy and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions, when the facility's infection control policy did not address facial hair and three staff members were observed in the kitchen without facial hair restraints. This affected 9 of 9 sampled residents (#s 1-9) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease causing pathogens. Findings included: The facility Food Services Infection Control policy was reviewed and it did not address facial hair. On 10/7/15 from 11:00 to 11:08 AM, during the observation of the kitchen and food temperatures, with the Dietary Services Manager (DSM) present, three male cooks were observed in the	F 371	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Dietary in-service was completed 10/21/15 and 10/22/15 on correct method of wearing beard nets. 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: The policy for "Food Services Infection Control—Dress Code for Dietary and Canteen Staff" was revised to include the regulation about beardnets from the Idaho Food Code. What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: Work order 13229 was submitted to the maintenance department to hang hairnet/beardnet storage boxes in the kitchen and Syringa Chalet Nursing Facility kitchenettes to make them more accessible.	11/12/15

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F 371	Continued From page 9 kitchen without a facial restraint to cover their mustache hair. Cook #1 had a facial hair restraint for the chin portion of his beard, but did not cover the mustache and was taking temperatures of food. Cook #2 and #3 were also observed in the kitchen. Cook #2 had a facial restraint for the chin portion of his beard, but it did not cover the mustache. Cook #3 had a mustache with one-to-two inches of facial hair and did not have a facial restraint on. On 10/7/15 the DSM stated she did not realize mustaches needed to be covered and immediately asked the cooks to cover their facial hair.	F 371	How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place: Dietary department will complete inspections for beardnet compliance 1x weekly for 8 weeks, 1x weekly q 2 weeks for 4 weeks, and then 1x per month for 2 months to ensure compliance. Administrator to ensure checks are completed. Results reported at Quarterly QA/PI meeting. Inspections to begin week of 11/2/15.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Morphine sulfate will be dispensed by a pharmacist daily Monday through Friday (excluding holidays) and taken over at med cart exchange. On Friday enough medication will be dispensed for the weekend and holiday if occurring. The pharmacist will inspect the medication upon dispensing to ensure it is in date. Morphine will be dispensed in a C2 box. At med cart exchange the nurse will open the C2 box and sign the dispense log, indicating that the nurse has received the medications. The nurse will inspect the medication along with the pharmacy technician as a double check that the medication is in date. At each cart exchange the pharmacy technician will exchange the C2 box with a new C2 box with the nurse and bring back any C2	11/12/15

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F 431	<p>Continued From page 10 have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents. This created the potential for sub-optimal efficacy for any resident who could have received the expired opioid analgesic, Morphine Sulfate. Findings included:</p> <p>On 10/7/15 at 3:45 PM, during an observation of the Second Street Medication Room with LN #6 in attendance, three pre-filled (.50 ml) syringes of Morphine Sulfate 1 mg/0.05 ml oral solution were found in a lock box in the medication cart with an expiration date of 4/30/2015. LN #6 observed the three syringes, stated they were expired and should not have been available for use. She stated she would inform their pharmacy, let the DNS know, and would dispose of the syringes according to their policy and procedure.</p> <p>On 10/7/15 at 5:00 PM, the DNS stated she had been made aware of the aforementioned expired medications.</p>	F 431	<p>medications that have not been used. At this exchange the nurse and pharmacy technician will both account for C2 medications that have not been used and both sign the dispense log under medications not used. Back at the pharmacy the pharmacist will review C2 medications that have come back in the C2 box. Any expired medications will be destroyed according to hospital policy.</p> <p>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: Pharmacy will do a monthly medication room inspection and will inventory all controlled substances and document any outdates that have been found. Any outdated medications will be taken from the medication room and destroyed according to hospital policy.</p> <p>What measures will be put in place or what systemic change will you make to ensure that the deficient practice does not recur: The pharmacist will inspect the medication upon dispensing to ensure it is in date. At the med cart exchange the nurse will open the C2 box and sign the dispense log, indicating that the nurse has received the medications and has verified that medication is in date. Upon return of the C2 box to pharmacy after cart exchange, the pharmacist will review what C2 medications have come back in the C2 box. Any expired medications will be destroyed according to hospital policy.</p>	
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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET (83221-4925) BLACKFOOT, ID 83221
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			<p>How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place:</p> <p>Documentation will be noted in saved C2 dispensing logs, which are saved in C2 locked cabinet, available anytime for review. Dispensing logs will be audited 1x weekly x 4, then q 2 weeks x 4, then monthly x 3 to ensure compliance. Results reported at Quarterly QA/PI meeting. Pharmacist or designee responsible. Audits to begin week of 11/2/15.</p>	
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001780	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
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NAME OF PROVIDER OR SUPPLIER
SYRINGA CHALET NURSING FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE
**700 EAST ALICE STREET (83221-4925)
BLACKFOOT, ID 83221**

(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility. The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Brad Perry, BSW, LSW	C 000		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting minutes, it was determined the facility failed to ensure a representative from each department was included and attended the ICC meetings every quarter. This failure created the potential for a negative effect for all residents including 9 of 9 sampled residents (#s 1-9), staff, and visitors to the facility. Findings included: The Infection Control Protocol was reviewed on 10/8/15 at 11:00 AM with the Infection Employee Health Nurse and CIC (Certified Infection Control) Practitioner. She stated the facility did not have sign-in sheets, however, the minutes included a list of who attended the meeting each quarter. Upon review of the minutes, it was determined the following ICC members did not attend/participate in the meetings at least quarterly: *1st Quarter, 1/29/15, Administrator, Pharmacist, DNS, and Maintenance; *2nd Quarter, 4/23/15, Maintenance; and,	C 664	The failure to ensure a representative from each department was included and attended the quarterly Infection Control Committee (ICC) Meetings created the potential for a negative effect for <i>all</i> residents including 9 of the 9 sampled residents, staff, and visitors to the facility. A sign-in sheet for required members has been created. Sign-in sheet will be used at the 10/29/15 ICC Meeting. Meeting requests will be sent out for the entire 2016 calendar year so required members of the committee can have the meeting on their schedule or send a representative in their absence. Compliance reported at the quarterly QA/PI meeting. Infection Control Nurse responsible.	11/12/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jamara Sullivan NHA, LCSW

Administrator

10/28/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001780	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/09/2015
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C 664	Continued From page 1 *3rd Quarter, 7/23/15, Pharmacist, Dietary, and DNS. On 10/8/15 at 5:30 PM, the Administrator and DNS were informed of the Infection Control concerns mentioned above.	C 664		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

TAMARA PRISOCK--ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T -- Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

November 9, 2015

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

Provider #: 135111

Dear Ms. Gillins:

On **October 9, 2015**, an unannounced on-site complaint investigation was conducted at Syringa Chalet Nursing Facility. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from October 5 to October 9, 2015.

The following observations were completed:

Blood Glucose checks were observed;
Call lights were observed;
Two traditional breakfasts and two continental breakfasts were observed;
Various employees were observed for appropriate dress and cell phone usage;
Medication Pass was observed; and,
Preventive skin measures were observed.

The following documents were reviewed:

The medical records of five identified residents were reviewed for Quality of Care concerns;
The medical records of five other residents were reviewed for Quality of Care concerns;
Nurse staffing records for August 6, 2015 and from September 13, 2015 to October 3, 2015 were reviewed;
The facility's Grievance file from February to October 2015;
Resident Council minutes from August to October 2015;
The facility's Incident and Accident reports from May to October 2015; and,
The facility's Allegation of Abuse reports from May to October 2015.

Tamara Gillins, Administrator
November 9, 2015
Page 2 of 8

The following interviews were completed:

Four residents and one family member were interviewed;

Six residents in the Resident Group meeting were interviewed;

Four nurses and three CNAs were interviewed; and,

The Medical Director, Director of Nursing Services (DNS), and Administrator were interviewed regarding various Quality of Care concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007154

ALLEGATION #1:

The complainant stated there are not enough staff to meet residents' needs. There were not enough staff on August 6, 2015. During the night shift, the staff can't accomplish all the work they need to accomplish, taking out the trash, restocking shelves, defrosting refrigerators, showering residents, and keep a staff member on the floor to meet residents' needs. Nurses were providing training to nurses who did not work in the nursing home side of the organization.

FINDINGS #1:

Call lights and response times were observed to be appropriate;
Staffing levels for August 6, 2015 and September 13, 2015 to October 3, 2015 were within acceptable standards; Resident council meeting minutes did not document an issue with staffing; Grievances did not document a concern regarding staffing issues;
The residents in the group interview did not voice concerns regarding staffing issues;
Four residents and a family member did not voice concerns with staffing;
Three night staff said they had enough time to complete the required tasks at night and still take care of the needs of the residents and always had a staff member on the floor; and,
The DNS and Administrator stated staffing levels were based on the acuity of the residents.

Based on observations, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident may have choked to death and a thorough investigation was not completed to determine the cause of death.

FINDINGS #2:

The facility's investigation of the incident was reviewed;
The identified resident's medical record was reviewed, including the cause of death;
A CNA and a nurse were interviewed and they did not know, at the time, how the resident expired;
The DNS was interviewed and stated there was a rumor the resident choked to death and she made attempts to investigate the rumor. She also said the death was investigated; and,
The Medical Director was interviewed and stated the resident did not choke to death.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

An identified employee wore flip-flops to work and used a personal cell phone during working hours in front of residents.

FINDINGS #3:

Employees were observed from October 5 to October 9, 2015 for flip-flops and cell phone usage;
Charge nurse work cell phones were observed to be used for work calls;
Six residents in the group interview said there were no concerns with employee dress and cell phone usage;
Four staff members were interviewed and said they had not seen employees wear flip-flops during work, nor had seen cell phones used for personal use during work hours; and,
The DNS said floor nursing staff were required to wear closed-toed shoes and were not allowed to use personal cell phones.

Based on observation, record review, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

Tamara Gillins, Administrator
November 9, 2015
Page 4 of 8

ALLEGATION #4:

On August 6, 2015 from 7:00 AM to 7:00 PM, no orders were processed until the night shift.

FINDINGS #4:

All resident orders from August 6, 2015 from 7:00 AM to 7:00 PM were reviewed and were processed in a timely manner.

Six other residents' orders were reviewed and were processed in a timely manner.

The DNS said orders were processed when they were received and were reviewed by night shift nurses to ensure accuracy.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

There were many falls in the facility and an identified resident did not have adequate supervision when he/she fell and fractured a leg.

FINDINGS #5:

The identified resident was reviewed for falls and adequate supervision was provided;

Seven other residents were reviewed for falls and adequate supervision was provided;

The identified resident was interviewed regarding his/her falls;

The DNS and Administrator said the facility provided adequate supervision based on the resident's preferences and money was never a factor regarding the resident's supervision needs.

Based on record review and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Nurses are not allowed to contact the physician at night or on weekends directly and are required to work through the house supervisor to initiate contact with the physician.

FINDINGS #6:

Six residents' records were reviewed for a delay of treatment during night and weekend shifts; Two nurses were interviewed and said during the day they can call the physician directly, but at night and on the weekends they call the house supervisor first who contacts the physician on call. Staff said they receive a quick response to their requests and there has never been a delay of treatment based on this protocol; and, The DNS said the protocol allows nurses to discuss the issue at hand and there have been no delays in treatment based on the protocol.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

An identified resident's cardiac medications did not contain parameters.

FINDINGS #7:

The identified resident's cardiac medication orders were reviewed, parameters were documented and vital signs had been documented. The DNS said cardiac medication parameters are individualized based on the resident's needs; physician orders and any questions are clarified with the physician.

Based on the record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Blood glucose testing machines are not cleaned between residents.

FINDINGS #8:

The Infection Control policy regarding blood glucose machines was reviewed, A staff member was observed cleaning blood glucose machines between residents, and the Infection Control Nurse were interviewed, and said the machines were cleaned between residents.

Based on observation, record review, and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #9:

Some residents have orders to administer insulin.

FINDINGS #9:

Four residents' records were reviewed for diabetic management and none of the residents had orders to self-administer insulin.

A nurse was interviewed and said no residents in the facility self-administered insulin.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #10:

Five identified residents did not receive breakfast until 11:00 AM on August 29, 2015.

FINDINGS #10:

Two traditional breakfasts and continental breakfasts were observed to be served on time; Three of the five identified residents attended the group interview and said breakfasts were served on time. Residents said if they missed it then they could have a continental breakfast, which was served at 9:00 AM if they missed that, then staff always provided some sort of cereal or snacks;

Two CNAs were interviewed and said there were two opportunities for breakfast and snacks if residents did not wake up before lunch; and,
The DNS said if residents slept past both breakfasts, then they were always offered cereal, yogurt, snack bars, etc.

Based on observation, resident and staff interviews, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #11:

The facility did not have a skin program.

FINDINGS #11:

The DNS provided the facility's skin protocol, which was reviewed,
Two residents were reviewed for pressure ulcer prevention interventions, which were in place.
A nurse said the facility has a skin program and all the nurses have been trained in pressure ulcer prevention and treatment.

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #12:

Diabetic management is inadequate and there are no sliding scale insulin parameters.

FINDINGS #12:

One resident was observed receiving insulin during medication pass that was within parameters;
Records for four residents were reviewed for diabetic management;
Two nurses were interviewed regarding diabetic management and insulin administration; and,
The DNS was interviewed regarding diabetic management, and said residents receive appropriate diabetic care.

Tamara Gillins, Administrator
November 9, 2015
Page 8 of 8

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,


David Scott, R.N., Supervisor
Long Term Care

DS/lj