



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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August 24, 2016

Joe Cladouhos, Administrator  
Syringa General Hospital Hospice  
607 West Main Street  
Grangeville, ID 83530

RE: Syringa General Hospital Hospice, Provider #131534

Dear Mr. Cladouhos:

This is to advise you of the findings of the Medicare survey of Syringa General Hospital Hospice, which was conducted on August 19, 2016.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey. This form is for your records only and need not be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

NICOLE WISENOR, Supervisor  
Non-Long Term Care

NW/pmt  
Enclosures

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

PRINTED: 08/23/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>131534</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SYRINGA GENERAL HOSPITAL HOSPICE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>607 WEST MAIN STREET GRANGEVILLE, ID 83530</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	
L 000	<p><b>INITIAL COMMENTS</b></p> <p>A Recertification Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare and Medicaid (CMS) from 8/17/16 to 8/19/16. The Hospice was found in compliance with the requirements of 42 CFR 418, Conditions of Participation for Hospice. The surveyor conducting the survey was:</p> <p>Stephen Mickschl, RN, MS</p>	L 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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.