February 1, 2017

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

Provider #: 135111

Dear Ms. Gillins:

On January 13, 2017, 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 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. 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.
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 **February 13, 2017**. Failure to submit an acceptable PoC by **February 13, 2017**, may result in the imposition of penalties by **March 20, 2017**.

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 **February 17, 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 **April 13, 2017**. A change in the seriousness of the deficiencies on **February 27, 2017**, may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by April 13, 2017 includes the following:

Denial of payment for new admissions effective April 13, 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 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 July 12, 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, 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 April 13, 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:

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 **February 13, 2017**. If your request for informal dispute resolution is received after **February 13, 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, 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,

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures
The following deficiencies were cited during the federal recertification survey conducted at the facility from January 9, 2017 to January 13, 2017.

The surveyors conducting the survey were:
Nina Sanderson, LSW, Team Coordinator
Jenny Walker, RN
Edith Cecil, RN
Susan Costa, RN

Acronyms include:
ABHR = Alcohol Based Hand Rub
ADON = Assistant Director of Nursing
BG = Blood Glucose
CNA = Certified Nursing Assistant
COPD = Chronic Obstructive Pulmonary Disease
CPAP = Continuous Positive Airway Pressure
F = Fahrenheit
GG = Glucose Gel, also called Glutose Gel
H&P = History and Physical
LPN = Licensed Practical Nurse
LN = Licensed Nurse
LSW = Licensed Social Worker
mg/dl = milligram per deciliter
MD = Medical Doctor
MDS = Minimum Data Set
OSA = Obstructive Sleep Apnea
PA = Physician Assistant
PRN = as needed
RN = Registered Nurse
SCNF = Syringa Chalet Nursing Facility

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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<td>F 000</td>
<td>INITIAL COMMENTS</td>
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F 164 Continued From page 1

(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(h)(3) The resident has a right to secure and confidential personal and medical records.

(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.

§483.70
(i) Medical records.
(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors,

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### F 164

**Continued From page 2**

and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure a resident's privacy during social service assessments. This was true for one Random Resident (#11). The deficient practice created the potential for harm should Resident #11 become embarrassed when asked to provide private information in front of her peers in the dining room. Findings include:

- Resident #11 was admitted to the facility on 4/22/13, with diagnoses which included major depressive disorder.

- Resident #11’s care plan documented she struggled with multiple lifestyle changes, the need for nursing home placement, and had low self-esteem and sense of self-worth.

- On 1/10/17 between 12:37 pm and 12:50 pm, the LSW was observed sitting at a table in the First Street dining room with Resident #11. Twelve other residents were in the dining room. The LSW conducted MDS assessment interviews for mood and cognition, asked Resident #11 about difficulties her family members were having, and questioned Resident #11 as to whether she was using Klonopin to help her sleep at night. This interaction was easily overheard from a distance of approximately 20 feet.

- On 1/11/17 at 2:35 pm, Resident #11 recalled the conversation in the dining room on the previous

### F 164 PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

- Resident #11: MDS interviews for this resident will be conducted in a private setting to maintain confidentiality, avoid distractions and promote open communication.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

- Since all other residents could be affected by the same deficient practice, MDS interviews for all residents will be conducted in the same setting as described above.

What measures will be put in place and what systemic change will be made to ensure that the deficient practice does not recur:

- Clinical Social Worker will keep a log identifying the setting in which all resident
### F 164
Continued From page 3

Day. Resident #11 stated the LSW had asked if she could sit and talk with her. Resident #11 stated she gave permission for the LSW to sit and talk with her, but did not know the LSW was going to be conducting assessment interviews or discussing personal family matters. Resident #11 stated she would have done a better job on the memory part of the assessment had she been in a quieter setting where she was not so distracted. Resident #11 stated, "I didn't realize some of that information could be overheard, or that it was overly private, but it's OK. I like [the LSW]."

On 1/12/17 at 9:30 am, the LSW stated she had approached Resident #11 in the dining room on 1/10/17 to ask when it would be convenient to meet with her. The LSW stated Resident #11 had indicated she was available at that time. The LSW stated she had not considered the private nature of the information which she planned to discuss, or the presence of other residents and staff, prior to conducting the assessments and interviews in a public place.

### F 241

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<th>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY</th>
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(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

This REQUIREMENT is not met as evidenced by:
- Based on observation, resident and staff interview, and record review, it was determined the facility failed to treat residents in a dignified manner.

MDS interviews are conducted.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

Administrator/Designee will observe Clinical Social Worker in the setting in which MDS interviews are conducted to ensure they are in a private setting. There will be a section of the log for comments/initials of the person doing the observation. Observation to continue on all MDS interviews for 8 weeks.
F 241 Continued From page 4

manner. This was true for 2 of 9 sample residents (#3 and #8) and 4 random residents (#12 - #15). The deficient practice resulted in a resident who was seldom incontinent, wearing incontinent briefs as he believed it was required, and experiencing embarrassment when wearing the incontinent briefs. The deficient practice also created the potential for residents to become embarrassed when addressed in an infantile manner or otherwise disregarded during meals; when served meals on Styrofoam plates and/or with plastic utensils; and when clothing protectors were placed on them before the residents' granted permission. Findings include:

1. Resident #3 was admitted to the facility on 12/21/16, following hospitalization for respiratory failure. His admission H&P dated 12/21/16, documented he denied any problems with urination, incontinence, or discharge. The admission nursing assessment, performed on 12/21/17, documented Resident #3 was continent of bowel and bladder.

During an interview on 1/13/17 beginning at 9:50 am, Resident #3 stated he was wearing incontinent briefs. He stated he "Thought it was required," and because they were provided to him, he put them on. Resident #3 stated he was seldom incontinent, and it was at night when he had too much to drink. He said he was embarrassed to wear the incontinence briefs.

During an interview on 1/12/17 beginning at 12:20 am, RN #1 reviewed Resident #3's record. He stated Resident #3 had rare instances of incontinence, and said that he have the option to refuse wearing the incontinence briefs. He stated

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #3: An incontinence assessment was completed and resident no longer requiring incontinence briefs.

Resident #8: Staff will ask permission to use a clothing protector and choice of placement (fastened around neck or placed in lap). Staff will explain what is being done. Melamine dinnerware and stainless steel silverware will be used instead of Styrofoam plates and/or plastic utensils with all meals. Staff will address resident and encourage her to open mouth and eat in a respectful, adult-like manner. Staff will sit vs standing and give full attention to resident while assisting with feeding. Staff will work as a team to accommodate needs of other residents. Any spilled food on chin will be wiped away with a napkin. Proper hand hygiene will be used between residents when assisting with feeding, using the intercom, touching equipment/wheelchairs, and when leaving and returning to the dining room.

Resident #15: Staff will be attentive to accommodating resident's requests in a timely manner and in a cordial tone of voice. All staff will work as a team to meet individual needs and give sufficient time to finish meals.
### SYRINGA CHALET NURSING FACILITY

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 241</td>
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<td>he was not aware that Resident #3 did not want to wear them.</td>
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<td>2. Resident #8 was admitted to the facility on 3/26/10. Her diagnoses included dementia.</td>
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<td>Resident #8's 12/27/16 Annual MDS assessment documented she was dependent on staff for eating.</td>
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<td>On 1/11/17 at 5:16 pm, Resident #8 was sitting in the First Street dining room. The meal progressed as follows:</td>
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<td>* 5:16 pm: CNA #3 placed a clothing protector on Resident #8 without explaining what was being done or asking the resident's permission.</td>
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<td>* 5:20 pm: CNA #2 sat to assist Resident #8 eat her dinner meal. CNA #2 stated, &quot;She needs plastic silverware.&quot; RN #1 brought CNA #2 three plastic spoons. CNA #2 used the plastic spoons to feed Resident #8.</td>
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<td>* 5:21 pm: Resident #15, sitting at a table adjacent to Resident #8's table, asked loudly for a slice of bread. CNA #2, still feeding Resident #8, replied loudly that bread was not available.&quot; Resident #15 again asked loudly for a slice of bread. Still assisting Resident #8, CNA #2 told Resident #15 bread was not available and offered sugar packets instead.</td>
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<td>* 5:22 pm: CNA #2 scooped a spoonful of food and attempted to feed it to Resident #8. Resident #8 did not open her mouth. CNA #2 backed the spoon away from Resident #8's mouth and began stating &quot;Yum yum yum,&quot; in an infantile manner, while arcing the spoon through the air towards Resident #8's mouth.</td>
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<td>* 5:24 pm: Resident #15 asked for chocolate</td>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 EAST ALICE STREET  
BLACKFOOT, ID  83221

**DATE SURVEY COMPLETED**

01/13/2017

**ID PREFIX TAG**

135111
**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: 01/13/2017

**NAME OF PROVIDER OR SUPPLIER**

SYRINGA CHALET NURSING FACILITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 EAST ALICE STREET
BLACKFOOT, ID 83221

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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milk. CNA #2 stood from assisting Resident #8, retrieved a container of chocolate milk for Resident #15, then sat and resumed assisting Resident #8.

* 5:30 pm: CNA #2 attempted to place a spoonful of food into Resident #8's mouth. The resident did not open her mouth. CNA #8 stated, "Here you go, honey," in an infantile manner in an effort to get Resident #8 to open her mouth.

* 5:40 pm: CNA #2 scooped a spoonful of food and attempted to feed it to Resident #8. Resident #8 did not open her mouth. CNA #2 backed the spoon away from Resident's mouth. CNA #2 then opened her own mouth wide and began stating "Aaaahhh" as she moved the spoon towards Resident #8's mouth. Resident #8 opened her mouth slightly and CNA #2 placed the spoonful of food into Resident #8's mouth. A small amount of the food on the spoon spilled onto Resident #8's chin. CNA #2 used the spoon to scrape the spilled food from Resident #8's chin and place it in her mouth.

* 6:10 pm: CNA #3 was standing up and feeding Resident #8. She turned to assist with Resident #14, taking his utensil and offering him a bite of food. Hand Hygiene was not performed between residents.

* 6:13 pm: CNA #2 returned to Resident #8 and offered her food. She responded to the intercom on the wall and spoke with another resident on the intercom.

* 6:20 pm: CNA #2 offered Resident #14 more food.

* 6:22 pm: CNA #2 turned to Resident #8 and spooned food into her mouth. She then walked out of the dining room.

* 6:25 pm: CNA #2 returned to the dining room, pushing a resident in a wheelchair up to a table.

**F 241**

Proper hand hygiene will be used and any spilled food will be wiped away with a napkin.

What measures will be put in place and what systemic change will be made to ensure that the deficient practice does not recur:

Staff members will be assigned as dining room monitors and use a Dining Room Checklist listing all specific areas needing improvement as noted above. In-services were held 2/6/17, 2/7/17, 2/13/17, 2/14/17.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

A staff member will monitor the dining room 6 meals weekly (2 breakfast, 2 lunches and 2 dinners) x 2 weeks, then 3 meals weekly (1 breakfast, 1 lunch, 1 dinner) x 4 weeks to ensure compliance. Audit results reported at Quarterly QA Meetings.
F 241 Continued From page 7
* 6:30 pm: CNA #2 attempted to clear Resident #15's plate and eating utensils. Resident #15 stated she was not yet done. CNA #2 assisted Resident #15 by spooning food into her mouth, offering her 3 bites, then cleared her eating utensils, plate, glass and clothing protector.
* 6:35 pm: CNA#3 cleared the plate, glass, eating utensils and clothing protector from Resident #14.

On 1/11/17 at 6:10 pm, the ADON stated there was no reason for Resident #8 to have plastic utensils, and stainless silverware should have been provided. The ADON stated it would not be acceptable for staff to use baby talk or infantile words or gestures while assisting residents, and other staff in the dining room should have addressed Resident #15’s requests for a slice of bread or chocolate milk.

3. On 1/10/17 at 12:23 pm, LPN #2 brought Resident #12 into the First Street dining room for his lunch meal. The lunch meal was still being served. Both Resident #12 and LPN #2 were wearing winter coats. LPN #2 removed her coat, then Resident #12's coat. CNA #3 placed a clothing protector around Resident #12's neck without asking him if he wanted a clothing protector. LPN #2 stated Resident #12 had just returned from an appointment, and asked to have his lunch brought to him. LPN #2 was informed Resident #12's meal had already been placed in the refrigerator and would need to be heated up. At 12:28 pm, LPN #2 brought Resident #12 his lunch meal on a Styrofoam plate, and gave Resident #12 plastic utensils.

On 1/11/17 at 6:10 pm, the ADON stated
**SUMMARY STATEMENT OF DEFICIENCIES**

*Each deficiency must be preceded by full regulatory or LSC identifying information*

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<tr>
<td>483.10(i)(6) COMFORTABLE &amp; SAFE TEMPERATURE LEVELS</td>
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Resident #12 had a doctor's appointment the day before, and the facility had set his lunch aside as they were not sure what time he would be back. The ADON stated the facility should have transferred the resident's meal to regular dishes after it was heated up, and provided regular silverware. The ADON stated residents should be offered the choice of a clothing protector, and should be offered the opportunity to have it placed in their lap as opposed to automatically fastening it around their neck.

4. On 1/10/17 at 12:29 pm, Resident #13 was sitting at a table in the First Street dining room with her lunch plate in front of her. Resident #13 was not eating her meal. LPN #2 approached Resident #13, and while standing, picked up Resident #13's fork, speared a forkful of food, and attempted to feed it to Resident #13. The resident declined the food.

On 1/11/17 at 6:10 pm, the ADON stated staff should not stand while assisting residents with their meals.

(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F.

This REQUIREMENT is not met as evidenced by:

- Based on Resident Group interview, observation, ambient temperature evaluation, hard surface temperature evaluation, and resident and staff interview, it was determined the facility failed ensure comfortable and safe
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<th>Summary Statement of Deficiencies</th>
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<td>F 257 have been affected by the deficient practice:</td>
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<td>temperature levels were maintained in the dining rooms on the first and second floors. This was true for 2 of 2 Random Residents (#16 and #18), and all other residents who used one or both of the dining rooms for meals and/or activities. This practice created the potential for residents to resist going to the dining rooms for meals or participate in activities held in the dining rooms. Findings include:</td>
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<td>On 1/10/17 at 10:00 am, Resident Group interview was held in the first floor dining room. The residents were asked if the room temperature was comfortable for them. Resident #16 stated the windows in the dining room are old and drafty.</td>
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<td>On 1/10/17 at 12:30 pm, Resident #18 was observed sitting at a table near the window in the second floor dining room during the lunch meal. Resident #18 wore a jacket and a stocking cap during the meal. The thermostat on the wall in the dining room read 70 degrees Fahrenheit (F).</td>
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<td>On 1/11/17 at 5:30 pm, Resident #18 was observed sitting at a table near the window in the second floor dining room during the evening meal. Resident #18 wore a jacket and a stocking cap during the meal. The thermostat on the wall in the dining room read 70 degrees F.</td>
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<td>On 1/12/17 at 10:00 am, Maintenance Employee #1 evaluated the surface temperature of the tables in the first floor dining room. Table surface temperatures near the windows ranged from 65 to 66 degrees F.</td>
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<tr>
<td>On 1/12/17 at 10:15 am, Maintenance Employee</td>
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Residents #16 and #18: Syringa Administrator consulted with the Fire and Construction Safety Supervisor at the Bureau of Facility Standard regarding what heaters might be purchased that would meet regulatory standards as the Supervisor is very familiar with our dated building. Free-standing heaters were purchased and placed along-side the outer cement walls in both dining rooms. Staff understands that although the dining rooms may meet regulatory requirements, individual preferences may vary. Care is given with any resident showing signs of discomfort (hot or cold) to adjust clothing and/or move resident to a different area in the dining room.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

Since all other residents could be affected by the same deficient practice, the same measures identified above apply. In-services held 2/6/17, 2/7/17, 2/13/17, 2/14/17.

What measures will be put in place and what systemic change will be made to ensure that the deficient practice does not recur:

Prior to the survey, thermostats in both
<table>
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<tr>
<th>F 257</th>
<th>Continued From page 10</th>
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</thead>
<tbody>
<tr>
<td>#1 evaluated the surface temperature of the tables in the second floor dining room. Table surface temperatures near the windows ranged from 66 degrees to 66.5 degrees F. Maintenance Employee #1 stated, &quot;I didn't realize it was so cold in the dining rooms.&quot;</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>F 271</th>
<th>483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Admission orders</td>
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</table>

At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff and resident interviews, it was determined the facility failed to ensure residents received orders for essential dining rooms were placed close to the exit doors, but the readings didn't give an accurate representation of how cold it could get next to the circular outside cement wall with widows. An additional thermostat was placed alongside the outside wall in each dining room. Additionally, if the free-standing units are not sufficient to maintain the required temperature, two ceiling-mounted heaters were purchased and will be installed.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

Temperatures will be taken during day, evening and night shifts 5 days a week x 4 weeks, then 2 days a week x 8 weeks. Additionally, if there is an especially cold day, temperatures will be checked and heat adjusted to ensure resident comfort. Audit results reported at Quarterly QA Meetings.
### Summary Statement of Deficiencies

**F 271**

Continued From page 11

Medical equipment based on their diagnosis. This affected 1 of 6 residents (#3) reviewed for medical equipment. This failure created the potential for more than minimal harm should Resident #3 experience heart failure, a heart attack, a stroke, headaches, and/or fatigue, due to untreated sleep apnea. Findings include:

Resident #3 was readmitted to the facility on 12/21/16, following hospitalization for respiratory failure. His medical H&P included a diagnosis of OSA (Obstructive Sleep Apnea). The physician who performed the H&P on 12/21/16, documented Resident #3 had a CPAP machine. However, the CPAP machine and use of it were not included on Resident #3's admission and subsequent orders. Resident #3’s Care Plan included a focus area titled “Oxygen Therapy Related to COPD, and hypoxemia with activity.” His care plan included diagnoses of OSA, sleep related hypoventilation, and COPD. Resident #3’s record did not include nursing notes or further documentation related to a CPAP machine.

During an interview on 1/13/17, Resident #3 stated he had used a CPAP for “years,” and said he did not know why it was not provided for his use during the present admission at the facility.

During an interview on 1/13/17 beginning at 10:00 am, the ADON reviewed Resident #3’s record and stated he used a CPAP at night on his prior admissions to the facility. She stated she did not know why it was not ordered on his current admission.

---

### Provider's Plan of Correction

**F 271**

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

- Resident #3: Physician Orders written, CPAP machine obtained, care plan updated to reflect current status.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

- Since all other residents could be affected by the same deficient practice, all residents were reviewed to ensure they had needed medical equipment. There were no other residents identified without needed medical equipment.

What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:

- Physician, DNS/ADNS will review documentation received from the referring facility for needed medical equipment prior to transfer to ensure Physician Orders are written and equipment is available at time of admission.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

- Physician, DNS/ADNS will review documentation received from the referring facility for needed medical equipment prior to transfer to ensure Physician Orders are written and equipment is available at time of admission.
## Summary Statement of Deficiencies

### F 281

**SS=E 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality. 

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined the facility failed to ensure LNs documented administration of medications after they were administered, consistent with current standards of practice. This was true for 2 of 2 LNs (RN #2 and LPN #2) and affected 6 of 6 residents (#1, #7, #12, #16, #17 and #20) observed during medication preparation, administration and documentation. This failure created the potential for medication errors, inaccurate documentation, and negative outcomes if residents were to receive the wrong medications. Findings include:

According to Lippincott Nursing Center, an online professional resource, accessed on 1/19/17, there are 8 rights of medication administration. It stated:

Right #6 - Documentation, "Document

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Residents #1, #7, #16, #17 and #20 (#12 discharged): In determining an acceptable plan of correction for these residents and this F-Tag, several SHS/Syringa Administrative/Management staff along with Pharmacy Director and IT Director had a conference call with the Bureau Chief on 2/6/2017. As we reviewed our current medication administration process, we determined there were ways to improve. It had been our process to keep the med cart in the

### F 271

Continued From page 12

Administrator to review every admission with DNS/ADNS on an on-going basis to ensure residents have required medical equipment. Results reported at Quarterly QA Meetings.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 271</td>
<td>Continued From page 12</td>
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<tr>
<td>F 281</td>
<td>483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
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<tr>
<td></td>
<td>(b)(3) Comprehensive Care Plans</td>
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<td></td>
<td>Right #6 - Documentation, &quot;Document</td>
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**Provider’s Plan of Correction**

**SS=E 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Residents #1, #7, #16, #17 and #20 (#12 discharged): In determining an acceptable plan of correction for these residents and this F-Tag, several SHS/Syringa Administrative/Management staff along with Pharmacy Director and IT Director had a conference call with the Bureau Chief on 2/6/2017. As we reviewed our current medication administration process, we determined there were ways to improve. It had been our process to keep the med cart in the
F 281 Continued From page 13 administration AFTER giving the ordered medication.*

The following examples are of medications prepared and documented as given before the LN left the medication room to administer the medications:

a. 1/11/17 at 6:35 pm, Resident #17 was in the dayroom on First Street, and received Tamsulosin and Gabapentin. His medications were prepared and documented as given by RN #2 before they were administered.

b. 1/11/17 at 6:40 pm, Resident #12 received Tamsulosin, Naproxen, Docusate and Remeron in his room. His medications were prepared and documented as given by RN #2 before they were administered.

c. 1/11/17 at 6:55 pm, Resident #7 received Haldol, Glycopyrolate, Docusate, Atorvastin, Clozapine, TYLENOL, Lorazepam, and Advair in her room. Her medications were prepared and documented as given by RN #2 before they were administered.

d. 1/11/17 at 7:05 pm, Resident #16 received Remeron, Quetiapine, Memantine, Gabapentin, Gemfibrozil, and eye drops in her room. Her medications were prepared and documented as given by RN #2 before they were administered.

e. 1/12/17 at 1:51 pm, Resident #20 received insulin in his right upper arm. His medication was prepared and the injection site documented by LPN #2 before the insulin was administered.

F 281 med room, but we determined it would be better to wheel the cart to the resident’s location or point of contact (ensuring privacy and not interrupting the dining experience). The nurse would then scan the barcode on the resident’s picture, scan the barcode on the unit dose medication and administer the medication in one continuous motion. If the medication is refused or spit out, the medication nurse will use the drop box to identify the reason why the medication is not given while still at the point of contact.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

This deficient practice has the potential to affect all other residents; thus, the corrective action(s) described above apply to all other residents. Nurses in-serviced on 2/7/17 and 2/13/17.

What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:

All needed supplies and bulk medication (e.g., M.O.M.) were moved to the med carts so the licensed nurse could scan, prepare and administer meds in one continuous motion. Batteries in the scanners and lap tops were also checked to ensure they would support the entire med pass away from an electrical outlet.
F 281 Continued From page 14  
f. 1/12/17 at 2:00 pm, Resident #1 received insulin in his right arm. His medication was prepared and the injection site documented by LPN #2 before the insulin was administered. 

On 1/12/17 at 2:15 pm, RN #1 identified himself as the charge nurse, and was present during the medication preparation, documentation, and administration for Residents #1 and #20. He stated the staff documented medications as given before they were administered. He said if the medication unit dose packages were torn on the barcode, the hand held scanner would not accurately scan. He stated if a medication was not taken, such as a refusal or if it fell on the floor, the LN could go back into the system and document the medication as not given.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.

The different nurses on Syringa scheduled to pass meds each week will each be observed 1 x weekly x 3 weeks, then every 2 weeks x 4 weeks to ensure compliance. Results reported at Quarterly QA Meetings.

F 309 2/17/17  
483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

483.24 Quality of life  
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care.

483.25  
(k) Pain Management.  
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents’ goals and preferences.
F 309 Continued From page 15

(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:

Based on staff interview, policy review, and record review, it was determined the facility failed to ensure nursing staff provided hypoglycemia interventions as ordered for 1 of 6 residents (#3) reviewed for diabetic management. This deficient practice placed residents at risk of further health complications as a result of inadequate diabetic management. Findings include:

Resident #3 was admitted to the facility on 12/21/16, following hospitalization for respiratory failure. Additional diagnoses included insulin dependent diabetes, diabetic and alcoholic neuropathy and chronic pain.

Resident #3's record included a blood glucose monitoring log for the dates 12/21/16 to 1/10/17. Resident #3's physician orders, dated 12/21/16, documented he was to have his blood glucose (BG) tested 4 times daily, before each meal and at bedtime. Resident #3's BG monitoring log documented 6 episodes of hypoglycemia during that period.

Resident #3's physician orders included the following facility protocol for hypoglycemia management. The Treatment of Hypoglycemia Protocol, dated 1/12/16, included the following:

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #3: The protocol for the treatment of hypoglycemia was reviewed with nursing staff on 2/7/17 and 2/13/17. Two timers were purchased to put on each med cart to alert nurses to follow the interventions identified in the protocol in a timely manner (e.g. BG levels rechecked, giving hypoglycemic snacks, administering Glucose Gel, notification of House Supervisor and Physician). Additionally, a 24-hr. chart review will completed each morning for this resident (per monitoring schedule as outlined in the final question in this tag) to assess stability of resident status, ensure that all episodes of hypoglycemia were documented, treatment was given per protocol, and documentation was completed. Additionally, the protocol was posted in each med room.

How will you identify other residents who...
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<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 309</td>
<td></td>
<td>Continued From page 16</td>
<td>F 309</td>
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<td>have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:</td>
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<td>* Following a reading of &lt;70 mg/dl, BG levels should be rechecked every 15 minutes until the glucose remains above 70 mg/dl for two consecutive readings.</td>
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<td>Since all other residents requiring diabetes management could be affected by this same deficient practice, all other residents with orders for BG checks were identified and the same procedure described above will be initiated.</td>
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<td>* Once glucose is &gt;70 mg/dl, offer the resident one designated &quot;hypoglycemic&quot; snack located in the medication room.</td>
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<td>What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not recur:</td>
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<td>* If interventions include administering Glucose Gel, contact the house supervisor.</td>
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<td>As noted above, a timer will be placed on each med cart alerting the nurses regarding following the time-frames within the protocol for different interventions. A 24-hour chart review for all residents with BG orders will be completed each morning for the previous 24 hours (per frequency noted below) to assess resident status, ensure all episodes of hypoglycemia were documented, the protocol followed, and documentation completed. Nurses in-serviced 2/6/17 and 2/13/17.</td>
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<td>* If BG is &lt;60 mg/dl, notify the physician, review glucose readings and medications.</td>
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<td>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:</td>
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<td></td>
<td>* If BG is &lt;60 mg/dl, notify RN manager and/or DNS</td>
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<td>A chart review for all residents with BG orders will be completed each morning for the previous 24 hours 5 x weekly x 4</td>
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<td>The Protocol included three categories of hypoglycemia, and the responsibility of the LN to provide specific treatment. The categories were:</td>
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<tr>
<td></td>
<td></td>
<td>* Mild (BG 60-70 mg/dl),</td>
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<td></td>
<td>* Moderate to Severe, Responsive, (BG &lt;60 mg/dl)</td>
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<td></td>
<td></td>
<td>* Moderate to Severe, Unresponsive, (BG &lt;60 mg/dl)</td>
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<td>The Protocol also stated:</td>
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<td>* If a resident could swallow and experienced mild hypoglycemia [BG 60-70 mg/dl], 15 gm of Glucose Gel (GG) was to be administered orally.</td>
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<td>The resident's BG level was to be checked in 15 minutes and if it remained 60/70 mg/dl, 15 gm of GG was again administered and the resident's BG level checked in 15 minutes. After the BG was &gt;70 mg/dl, a designated snack from the medication room was to be provided.</td>
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<td>* If a resident experienced moderate to severe hypoglycemia [BG less than 60 mg/dl] and could</td>
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*x Following a reading of <70 mg/dl, BG levels should be rechecked every 15 minutes until the glucose remains above 70 mg/dl for two consecutive readings.

* Once glucose is >70 mg/dl, offer the resident one designated "hypoglycemic" snack located in the medication room.

* If interventions include administering Glucose Gel, contact the house supervisor.

* If BG is <60 mg/dl, notify the physician, review glucose readings and medications.

* If BG is <60 mg/dl, notify RN manager and/or DNS

The Protocol included three categories of hypoglycemia, and the responsibility of the LN to provide specific treatment. The categories were:

* Mild (BG 60-70 mg/dl),

* Moderate to Severe, Responsive, (BG <60 mg/dl)

* Moderate to Severe, Unresponsive, (BG <60 mg/dl)

The Protocol also stated:

* If a resident could swallow and experienced mild hypoglycemia [BG 60-70 mg/dl], 15 gm of Glucose Gel (GG) was to be administered orally. The resident's BG level was to be checked in 15 minutes and if it remained 60/70 mg/dl, 15 gm of GG was again administered and the resident's BG level checked in 15 minutes. After the BG was >70 mg/dl, a designated snack from the medication room was to be provided.

* If a resident experienced moderate to severe hypoglycemia [BG less than 60 mg/dl] and could
<table>
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<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td></td>
<td>Continued From page 17 swallow, 30 gm of GG was to be administered orally, followed by a BG check 15 minutes later. If the BG result was then 60/70 mg/dl, the GG and BG check was to be repeated. After the BG was &gt;70 mg/dl, a designated snack from the medication room was to be provided. Facility staff did not follow the above protocol when Resident #3 experienced hypoglycemic episodes. Examples include:</td>
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<td>* On 12/27/16 at 8:29 pm, Resident #3's BG level was 50. - Resident #3's SCNF Alert Charting for 12/27/16 at 7:46 pm, documented &quot;Resident refused dinner. Resident self isolating in room. Resident had and [sic] unwitnessed fall to the floor while [sic] self transferring [sic] to camode [sic] from wheelchair. Resident refused vital signs and states he is ok.&quot; His record did not include documentation of this episode of hypoglycemia. - Resident #3 was administered 15 gm of GG at 8:31 pm. The protocol specified 30 gm of GG was to be administered for a BG level &lt;60 mg/dl. - At 9:19 pm, 49 minutes after the GG was administered, his BG level was documented as 133. - His record did not include documentation that his BG was monitored every 15 minutes until his BG remained above 70 mg/dl for two consecutive readings. Additionally, his record did not document a designated snack from the medication room was provided. - Resident #3's record did not include documentation the LN notified his physician to review glucose readings and medications. - His record did not document the house supervisor was notified, as directed in the weeks, then 3 x weekly, x 3 weeks then 1 x weekly times 2 weeks to ensure compliance. Results reported at Quarterly QA Meetings.</td>
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<td>F 309 weeks, then 3 x weekly, x 3 weeks then 1 x weekly times 2 weeks to ensure compliance. Results reported at Quarterly QA Meetings.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>135111</td>
<td>A. BUILDING:_</td>
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<tr>
<td></td>
<td>B. WING:_</td>
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</tbody>
</table>

**DATE SURVEY COMPLETED**

01/13/2017

**NAME OF PROVIDER OR SUPPLIER**

SYRINGA CHALET NURSING FACILITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 EAST ALICE STREET
BLACKFOOT, ID 83221

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**COMPLETION DATE**

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**F 309 Continued From page 18 protocol.**

- On 12/28/16 at 7:10 am, Resident #3's BG level was 49.
- Resident #3 was administered 15 gm of GG at 8:04 am, 54 minutes after the BG of 49 was performed. The protocol specified 30 gm of GG was to be administered.
- His BG level was drawn at 8:05 am, (1 minute after the GG was administered) and the result of 163.
- Resident #3's SCNF Alert Charting for 12/28/16, did not include documentation of the hypoglycemia episode.
- His record did not include documentation that his BG was monitored every 15 minutes until his BG level remained above 70 mg/dl for two consecutive readings. Additionally, his record did not document a designated snack from the medication room was provided.
- Resident #3's record did not include documentation the LN notified his physician to review glucose readings and medications.
- His record did not document the house supervisor was notified, as directed in the protocol.

- On 12/31/16 at 7:22 am, Resident #3's BG level was 52.
- Resident #3 was administered 15 gm of GG at 7:23 am. The protocol specified 30 gm of GG was to be administered.
- His BG level was rechecked at 8:11 am was 82 mg/dl. The recheck was performed 42 minutes after the GG was administered, instead of 15 minutes after, as stated in the protocol.
- Resident #3's SCNF Alert Charting for 12/31/16 at 1:29 pm, documented "Resident was..."
Continued From page 19

hypoglycemic in the AM and responded well to protocol treatment."

- His record did not include documentation that his BG was monitored every 15 minutes until his BG remained above 70 mg/dl for two consecutive readings. Additionally, his record did not document a designated snack from the medication room was provided.

- Resident #3's record did not include documentation the LN notified his physician to review glucose readings and medications.

- His record did not document the house supervisor was notified, as directed in the protocol.

* On 1/1/17 at 7:48 pm, Resident #3’s BG level was 56 mg/dl.
- Resident #3 was administered 15 gm of GG at 7:52 pm, however, the protocol specified 30 gm of GG.

- Resident #3’s SCNF Alert Charting for 1/1/17 at 9:33 pm, documented his BG level was 56 mg/dl, GG of 15 gm was administered, and a follow up BG was 111. The LN did not include the time of the BG result of 111 mg/dl, and the BG monitoring log did not include documentation of further monitoring of his BG level until 1/2/17 at 7:34 am.

- Resident #3’s record did not include documentation that his BG was monitored every 15 minutes until his BG remained above 70 mg/dl for two consecutive readings. Additionally, his record did not document a designated snack from the medication room was provided.

- Resident #3’s record did not include documentation the LN notified his physician to review glucose readings and medications.

- His record did not document the house
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<td>F 309</td>
<td>Continued From page 20</td>
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supervisor was notified, as directed in the protocol.

* On 12/26/16 at 7:36 am, Resident #3's BG level was 60 mg/dl.
- Resident #3 was administered 15 gm of GG at 7:56 am.
- His BG result of 88 mg/dl was performed at 8:44 am, which was 46 minutes after the GG, not 15 minutes after as ordered.
- Resident #3's SCNF Alert Charting for 12/31/16 at 10:22 am, completed by LPN #1, stated "Resident had a BG level of 60 mg/dl and was given Glutose Gel which brought his BG level to 88 mg/dl."
- His record did not include documentation that his BG was monitored every 15 minutes until his BG remained above 70 mg/dl for two consecutive readings. Additionally, his record did not document a designated snack from the medication room was provided.
- Resident #3's record did not include documentation the house supervisor was notified, as directed in the protocol.

* On 1/7/17 at 7:30 am, Resident #3's BG level was 62 mg/dl.
- Resident #3's medication administration record for GG did not document GG was given.
- His BG monitoring log did not include documentation additional BG checks were performed.
- Resident #3's SCNF Alert Charting for 1/7/17 at 10:02 am, completed by LPN #1, stated "Resident was hypoglycemic in the AM and responded well to protocol treatment."
- Resident #3's record did not include documentation the house supervisor was
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 01/13/2017

NAME OF PROVIDER OR SUPPLIER
SYRINGA CHALET NURSING FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE
700 EAST ALICE STREET
BLACKFOOT, ID 83221

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

(X5) ID PREFIX TAG

PROVIDER’S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

F 309
Continued From page 21
 notified, as directed in the protocol.

On 12/12/17 at 12:20 pm, RN #1 stated the Hypoglycemic Protocol was the same as a "Standing Order." He was able to demonstrate on the computer, in the Physician Order section, that Glucose Gel was ordered, with instructions to follow the Hypoglycemia Protocol. RN #1 reviewed Resident #3's record and a copy of the Hypoglycemia Protocol. Each of the above 6 examples of hypoglycemia and interventions were reviewed. RN #1 stated the protocol was not followed completely in all 6 examples.

F 315
SS=D

483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER

(e) Incontinence.
(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterization is
### F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER FUNCTION

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Resident #6: Resident was assessed on 1/23/17 for bladder incontinence. This assessment was compared to the assessment completed on 11/4/16. Resident continues to show a consistent pattern of being occasionally incontinent. The most recent assessment showed 5 episodes of incontinent bladder, whereas the previous assessment showed 3 episodes of incontinent bladder. She continues to be severely cognitively impaired per her BIMS score. With her cognitive deficits, she would not benefit from bladder retraining, however we do have the goal of maintaining bladder function.
Resident #6's current Care Plan stated she had bladder incontinence related to dementia. Interventions included "Check and change as required for incontinence." Resident #6's Care Plan did not include a toileting plan or bladder training program to reduce or eliminate incidents of incontinence.

On 1/12/17 at 11:40 am, RN #1 stated Resident #1 was not in a bladder training or toileting plan.

On 1/13/17 at 9:50 am, the ADON stated Resident #1 was severely cognitively impaired and would not benefit from a bladder training program.

function to the extent possible and reducing the number of incontinent episodes. Her care plan was revised. Since she can read, we posted a picture of a toilet with the word "Bathroom" (in large print) on her bathroom door and on the bathroom doors in the day rooms. Additionally, the care plan includes: 1. Encourage resident to use the restroom upon waking, before meals, after meals, and at bedtime. 2. Ensure the resident has an unobstructed path to the bathroom. 3. Commode at bedside. 4. Monitor/document for s/sx of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. 5. Clean peri-area with each incontinence episode. 6. Resident will wear briefs. 7. Incontinent: Check and change as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

Since all other residents have the potential to be affected by the same deficient practice, all residents will be thoroughly assessed with their next MDS to determine if a bladder training program could be initiated or additional
resident-specific interventions could be added to the care plan with the goal of reducing the incidence of incontinence and maintain or improve bladder function to the extent possible.

What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:

A section entitled, Bowel and Bladder Functioning will be added to the Treatment Team Agenda template where the MDS Coordinator will provide more thorough, comprehensive, comparative data regarding bowel and bladder functioning for residents being reviewed. The Treatment Team can determine at that time if a Bladder Retraining Program would be beneficial or additional resident-specific interventions are needed in the care plan. Additionally, a question will be added to the nursing admission assessment regarding prior patterns of bladder functioning.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

A chart review will be conducted for 4 months on every admission assessment to determine if information regarding prior patterns of bladder functioning was obtained. Additionally, weekly Treatment Team Meetings including the Physician,
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<td>F 315</td>
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<td>Continued From page 25</td>
<td>F 315</td>
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<td>PA and Geriatric Psychiatrist will be monitored 1 x weekly x 8 weeks to ensure processes described above are followed and compliance with Regulations. Results will be reported at Quarterly QA Meetings.</td>
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<td>F 329</td>
<td>SS=E</td>
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<td>483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</td>
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<td>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</td>
<td>2/24/17</td>
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<td>(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used—</td>
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<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</td>
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<td>(1) In excessive dose (including duplicate drug therapy); or</td>
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<td>(2) For excessive duration; or</td>
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<td>(3) Without adequate monitoring; or</td>
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<td>(4) Without adequate indications for its use; or</td>
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<td>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</td>
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<td>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medication had specific target behaviors identified and monitored. This was true for 4 of 6 (#1, #2, #4, and #6) sampled residents who received psychoactive medications. This deficient practice</td>
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<td>F 329</td>
<td>Continued From page 26 created the potential for more than minimal harm if residents received medications that may result in negative outcomes, without clear indication of need. Findings include:</td>
<td>F 329</td>
<td>Resident #6: The PA reviewed the Unit Dose Profile for this resident. Specific, well-defined target behaviors related to the diagnosis and specific drug ordered were identified and added to the Unit Dose Profile to justify the use of Zyprexa and Ativan. Zyprexa 5 mg, PRN, q 6 hours, Ativan 0.25 mg PO and Seroquel 5 mg PO were discontinued. These are the same behaviors monitored, tracked and quantified on the Behavior Tracking Log. Thus, there is continuity and consistency from the Unit Dose Profile to the Behavior Tracking Log limiting, monitoring, and tracking only specific target behaviors.</td>
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<td>1. Resident #6 was admitted to the facility on 10/24/16, with diagnoses which included depressive disorder, Alzheimer’s dementia and anxiety related to dementia.</td>
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<td>Resident #6's Admission MDS assessment, dated 10/31/16, documented she was severely cognitively impaired.</td>
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<td>Resident #6's Psychiatric Evaluation, completed by a PA on 10/28/16, and signed by the Staff Psychiatrist on 10/31/16, documented she was taking Effexor, Zyprexa, and Xanax prior to admission. The Psychiatric Evaluation documented Xanax would be discontinued, and Ativan would be ordered, &quot;so it is not needed as long.&quot; Additionally, the evaluation documented Effexor would be continued due to &quot;the long history of depression,&quot; and &quot;will continue the Zyprexa to augment the Effexor and help with mood stability.&quot; The Psychiatric Evaluation did not identify target behaviors that would require Zyprexa and Ativan administration.</td>
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<td>Resident #1: Diagnosis for this resident were revised to include Major Depression with psychotic features and personality disorder with dependent traits. The PA reviewed the Unit Dose Profile for this resident. Specific, well-defined target behaviors related to the diagnosis and specific drug ordered were identified and added to the Unit Dose profile. These are the same behaviors monitored, tracked and quantified on the Behavior Tracking Log limiting, monitoring, and tracking only specific target behaviors.</td>
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<td>Resident #6's Unit Dose Profile dated 1/11/17, documented:</td>
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<td>Resident #4: The PA reviewed the Unit Dose Profile for this resident. Specific, well-defined target behaviors related to the diagnosis and specific drug ordered</td>
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<td>* Zyprexa 5 mg each day at noon, diagnosis &quot;agitation.&quot; She was to receive additional doses of Zyprexa 5 mg, PRN, every 6 hours for &quot;mood instability.&quot;</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 329</td>
<td>Continued From page 27</td>
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<td>* Ativan 1 mg, orally, PRN, every 6 hours, diagnosis &quot;anxiety.&quot;</td>
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<td>* Interventions included:</td>
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<td>- &quot;Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness.&quot;</td>
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<td>- &quot;Monitor/record occurrence of for [sic] target behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc and document per facility protocol.&quot; The care plan included &quot;etc&quot;, indicating additional behaviors were to be documented, although the behaviors were not listed. The care plan did not include specific target behaviors the staff was to monitor.</td>
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<td>Resident #6's Psychotropic Care Plan, dated 11/10/16, documented:</td>
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<td>Resident #6's PRN psychotropic medications were ordered for mood instability, agitation, and anxiety. Resident #6's behavior tracking log, dated 11/6/16 to 1/8/17, and PRN Psychotropic Medication Notes dated 10/25/16 to 11/7/17, documented she received PRN medications. Examples include, but are limited to, the following:</td>
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<td>* Focus - &quot;The resident uses psychotropic medications r/t Dementia, Major Depression, and Anxiety.&quot;</td>
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<td>were identified and added to the Unit Dose Profile. These are the same behaviors monitored, tracked and quantified on the Behavior Tracking Log limiting, monitoring and tracking only specific target behaviors. Additionally, on this resident another area of deficiency was identified with behaviors being tracked by exception. Behaviors are now tracked on all shifts.</td>
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<td>* Interventions included:</td>
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<td>Resident #2: As described above, the same processes were used for this resident to ensure continuity and consistency. The PA reviewed the Unit Dose Profile for this resident. Specific, well-defined target behaviors related to the diagnosis and specific drug ordered were identified and added to the Unit Dose Profile. These are the same behaviors monitored, tracked and quantified on the Behavior Tracking Log limiting, monitoring, and tracking only specific target behaviors. Additionally, on this resident, another area of deficiency was identified with inconsistency in documenting target behaviors in Physician Progress Notes. Based on the entire process being revised, starting with the Physician’s Orders now identifying target behaviors, Physician Progress Notes will also discuss the specific target behaviors.</td>
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<td>- &quot;Monitor/record occurrence of for [sic] target behavior symptoms: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, etc and document per facility protocol.&quot; The care plan included &quot;etc&quot;, indicating additional behaviors were to be documented, although the behaviors were not listed. The care plan did not include specific target behaviors the staff was to monitor.</td>
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<td>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:</td>
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<td>F 329</td>
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<td>Since all other residents have the potential to be affected by this same deficient practice, the entire process as described above and summarized in the next question will be implemented. What measures will be put in place or what systemic change will be made to ensure that the deficient practice does not recur: The entire process of ensuring that a resident's drug regimen is free from unnecessary drugs has been revised. The PA has reviewed the Unit Dose Profile for all other residents to include specific, well-defined target behaviors related to the diagnosis and specific drug ordered and added these to the Unit Dose Profile. These are the same behaviors monitored, tracked and quantified on the Behavior Tracking Log limiting monitoring and tracking to only the specific target behaviors identified. The occurrences of these behaviors will be documented in one note entitled SCNF Behavior Note instead of 6 different notes. A new Behavior Tracking Log will only track the specific, target behaviors rather than a myriad of other behaviors. Monitoring/ tracking behaviors will occur on every shift rather than by exception. Staff in-serviced on 2/6/17, 2/7/17, 2/13/17, 2/14/17. How the facility plans to monitor performance to ensure the corrective measures were in place and adequate?</td>
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<td>* 10/25/16 at 6:20 pm - Ativan .25 mg PO was administered due to, &quot;Resident pacing halls with anxious expression on face.&quot;</td>
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<td>* 10/26/16 at 4:00 pm - Ativan .25 mg PO was administered due to, &quot;Resident pacing the halls going into peers rooms. Resident grabbing anything she can and reluctant to let go.&quot;</td>
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<td>* 11/7/16 at 5:30 pm - Zyprexa 2.5 mg PO was administered because Resident #6 was, &quot;Wandering halls, grabbing objects. Resident stated they were going to remove blood from staff.&quot;</td>
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<td>* 11/20/16 at 4:30 pm - Seroquel 5 mg PO was administered because, &quot;Patient was crying, stated, 'I'm sorry, I never do what they want me to do.'&quot;</td>
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<td>* 11/24/16 at 6:22 pm - 1 mg Ativan PO was administered for, &quot;Attempting to go into peers rooms and become [sic] agitated [sic] with staff when redirected.&quot;</td>
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<td>* 12/15/16 at 4:00 pm - Zyprexa 5 mg PO was administered because, &quot;Resident was being intrusive, argumentative and very hard to redirect.&quot;</td>
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<td>* 1/5/17 at 4:30 pm - Zyprexa 5 mg PO was administered because, &quot;Pt intrusive with peer interactions, pacing hall way [sic].&quot;</td>
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<td>* 1/10/17 at 3:15 pm - Ativan 1 mg PO was administered due to, &quot;Pt wandering throughout hall with troubled look on her face. Pt very confused.&quot;</td>
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On 1/11/17 at 10:45 am, the PA stated all behaviors were documented, and were not limited to specific target behaviors.
Resident #6 was administered routine and PRN psychotropic medications without resident specific, well defined, target behaviors identified.
2. Resident #1 was readmitted on 11/22/16 with a major depressive disorder, recurrent without psychotic features.
Resident #1’s Physician orders included Fluoxetine 20 mg dose to be given at bedtime for depression and Olanzapine 10 mg ordered to be given at bedtime as an antidepressant augmentation.
An MDS assessment completed 11/29/16 documented mild depression with rejection of care.
Resident #1’s Psychotropic Medication Use Care Plan, dated 6/13/16 and revised on 6/29/16, documented a diagnosis of major depression. The interventions did not identify target behaviors.
Resident #1’s Depression Care Plan, dated 12/8/16, did not identify target behaviors.
On 12/22/16, a PA progress note documented a diagnosis of major depression with psychotic features.
Progress Notes for January 2017 monitored Mood and Behavior symptoms which included: | F 329	action(s) are effective and compliance is sustained:
With each weekly resident MDS review, a checklist will be completed to ensure all elements of the process are followed and accurate on an on-going basis. Results will be reported at Quarterly QA Meetings. |             |                                                          |               |
**F 329** Continued From page 30

* Verbalizations or actions of hurting others or themselves.
* Sadness
* Worrying
* Hopelessness
* Refusals of meals or cares
* Wandering
* Hallucinations
* Delusions
* Disruptive behaviors

CNA flow sheets for January 2017 monitored the same Mood and Behavior symptoms noted above.

The Behavior Tracking Log form, from 11/1/16 through 1/4/17, documented behaviors exhibited by Resident #1 which included refusal of medications, cares, and meals, agitation (became upset), verbal aggression (thought he could not do for himself), delusions (thought family members were in his room stacking cups), sexual inappropriateness (discussed sausages), hallucinations (saw poltergeist, Satan, and figures crawling on the walls).

On 1/11/17, the ADON stated that residents' behaviors were charted by exception and any and all behaviors were documented.

It could not be determined from Resident #2's medical record that adequate indications for the use of psychoactive medications had been identified and monitoring for specific behaviors was in place.

3. Resident #4 was admitted on 9/15/16 with
**NAME OF PROVIDER OR SUPPLIER**
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<td>Continued From page 31 schizoaffective disorder-bipolar type.</td>
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<td>Resident #4's January 2017 Physician Orders included:</td>
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<td>* Divalproex 24 hour extended release 750 mg tab to be given daily for mood</td>
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<td>* Invega 234 mg injection to be given monthly for psychosis</td>
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<td>* Lorazepam 1 mg to be given every 6 hours prn (as needed) for agitation</td>
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<td>* Olanzapine 5 mg injection to be given daily prn for psychosis</td>
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<td>An MDS assessment completed on 12/13/16 documented behaviors which included delusions (misconceptions or beliefs that are firmly held, contrary to reality) and verbal behaviors (threatening others, screaming at others, cursing at others) identified 1-3 days out of the last 14 days.</td>
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<td>Resident #4's Psychosis Care Plan dated 9/16/16 documented a diagnosis of Schizoaffective and Bipolar Disorder and identified behaviors of making false accusations against staff and physical abuse with care.</td>
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<td>Resident #4's Psychotropic Drug Care Plan, dated 9/15/16 and revised on 12/22/16, documented interventions for monitoring the occurrence of target behaviors identified as pacing, wandering, disrobing, inappropriate response to verbal communication, and violence/aggression towards staff and others.</td>
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<td></td>
<td>Progress Notes for January 2017 monitored Mood and Behavior symptoms which included:</td>
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</table>
**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F329</td>
<td>Continued From page 32</td>
<td>F329</td>
<td>Each corrective action should be cross-referenced to the appropriate deficiency</td>
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</tbody>
</table>

- Verbalizations or actions of hurting others or themselves.
- Sadness
- Worrying
- Hopelessness
- Refusals of meals or cares
- Wandering
- Hallucinations
- Delusions
- Disruptive behaviors

CNA flow sheets for January 2017 monitored the same Mood and Behavior symptoms noted above.

The Behavior Tracking Log form, from 11/1/16 through 1/10/17, documented behaviors exhibited by Resident #4 which included refusal of medications, cares, and meals, agitation (refusing cares, MD appointments, x-rays), verbal aggression, (profanity, attempting to kick, punch, and scratch staff), delusions (believes she is an MD), and boundaries (self-isolating).

On 12/6/16 at 9:30 am, Resident #4 received a prn dose of Lorazepam for "agitation" described as refusing cares and refusing to go to the doctor's appointment.

On 12/6/16 at 10:30 am, Resident #4 received a prn dose of Olanzapine, injected for "agitation" described as uncooperative with going to x-ray appointment.

On 1/11/17 at 10:45 am, the ADON stated that behaviors were charted by exception and any and all behaviors were documented.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**A. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

135111

**B. WING _____________________________**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

SYRINGA CHALET NURSING FACILITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 EAST ALICE STREET
BLACKFOOT, ID  83221

**DATE SURVEY COMPLETED**

01/13/2017

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 329</td>
<td>Continued From page 33 It could not be determined from Resident #4's medical record that indications for the use of psychoactive medications had been identified and monitoring for specific behaviors was in place. 4. Resident #2 was admitted to the facility on 8/2/16 with multiple diagnoses, including schizoaffective disorder and dementia. The 11/1/16 quarterly MDS assessment documented Resident #2 did not experience hallucinations, delusions, or behaviors. The current Unit Dose Profile, dated 1/11/17, documented Resident #2 was receiving Risperidone 2 mg daily in the morning, initiated 9/8/16, and Risperidone 4 mg at bedtime for a diagnosis of psychosis, initiated 8/25/16. In addition, Resident #2 was to receive Risperidone 1 mg every 6 hours as needed for a diagnosis of psychosis, initiated 8/8/16. The physician orders did not specify how Resident #2's psychosis affected the resident and/or others. A Physician Progress Note, dated 8/25/16, documented Resident #2 experienced manic episodes. A Physician Progress Note, dated 9/8/16, documented Resident #2 experienced symptoms of psychosis and the Risperidone was increased to 2 mg in the morning. A Physician Progress Note, dated 11/17/16,</td>
<td>F 329</td>
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</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

135111

**MULTIPLE CONSTRUCTION**

A. BUILDING ____________________________

B. WING ____________________________

**DATE SURVEY COMPLETED**

01/13/2017

---

**NAME OF PROVIDER OR SUPPLIER**

SYRINGA CHALET NURSING FACILITY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

700 EAST ALICE STREET

BLACKFOOT, ID 83221

---

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID PREFIX TAG**

**F 329**

Continued From page 34 documented Resident #2 manic episodes had stabilized.

A Physician Progress Note, dated 1/5/17, documented Resident #2 was to remain on Risperidone to control symptoms of Schizoaffective disorder.

The Physician Progress Notes’ did not specify the signs or symptoms of Resident #2’s manic episodes and psychosis for staff to monitor or how those signs or symptoms were harmful to the resident and/or others.

Resident #2's Psychotropic Medication Care Plan, dated 8/18/16, documented, Resident #2 used psychotropic medications r/t Schizoaffective Disorder. Interventions included:

* Staff was to administer psychotropic medications as ordered by physician and monitor for side effects and effectiveness.

* Staff was to monitor Resident #2 for behavior symptoms and document per facility protocol. The documented behaviors on the care plan were pacing, wandering, disrobing, inappropriate response to verbal communication, and violence/aggression towards staff/others.

The care plan did not include resident-specific target behaviors staff were to monitor.

The behavior tracking log, dated 8/8/16 to 1/4/17, documented Resident #2 did not experience any behaviors as specified on the care plan.

On 1/11/17 at 10:45 am, the PA, Administrator,
### F 329
Continued From page 35
and ADON said the facility documents all behaviors, not specific target behaviors.

The facility failed to ensure resident-specific target behaviors were identified by the physician for use, and continued use, of a psychotropic medication. The resident-specific behaviors were not documented on the care plan or monitored by facility staff.

### F 364
483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP

(d) Food and drink

Each resident receives and the facility provides-

(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature;

This REQUIREMENT is not met as evidenced by:

Based observation and resident and staff interview, it was determined the facility failed to ensure residents were offered substitutes at meals, or that substitutes were provided timely. This was true for 3 random residents (#11, #13, and #16) and any resident requesting an alternate or substitute meal. The deficient practice created the potential for residents to lose interest in their meal or choose not to eat.

Findings include:

The facility is located on a campus with several other buildings. The kitchen is in a separate building from the facility, several minutes walking distance. There was a small serve-out kitchen

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<td></td>
<td>Continued From page 35 and ADON said the facility documents all behaviors, not specific target behaviors. The facility failed to ensure resident-specific target behaviors were identified by the physician for use, and continued use, of a psychotropic medication. The resident-specific behaviors were not documented on the care plan or monitored by facility staff.</td>
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</table>
| F 364     | 2/17/17 | 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides-
(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based observation and resident and staff interview, it was determined the facility failed to ensure residents were offered substitutes at meals, or that substitutes were provided timely. This was true for 3 random residents (#11, #13, and #16) and any resident requesting an alternate or substitute meal. The deficient practice created the potential for residents to lose interest in their meal or choose not to eat. Findings include: The facility is located on a campus with several other buildings. The kitchen is in a separate building from the facility, several minutes walking distance. There was a small serve-out kitchen |
F 364 Continued From page 36

with steam tables adjacent to each dining room in the facility.

a. On 1/10/17 at 12:11 pm, Resident #13 was served her noon meal in the First Floor dining room. Resident #13 did not eat her meal. Staff did not approach Resident #13 to inquire about her meal or offer a substitute. At 12:29 pm, LPN #2 attempted to feed Resident #13 her meal, but she declined assistance. LPN #2 did not inquire as to why Resident #13 was not eating her meal or offer her a different meal. LPN #2 offered Resident #13 an Ensure, yogurt, or Nutri-Grain bar. Resident #13 accepted the Ensure.

b. On 1/11/17 at 2:35 pm, Resident #11 stated she usually liked the facility's food, but when she did not like it she could "usually" get something else. Resident #11 stated, "The kitchen people sometimes say no." Resident #11 stated she believed this happened if she "changed her mind too much" about what she wanted to eat.

c. On 1/11/17 at 5:09 pm, Resident #16 was sitting in the First Street dining room with her dinner meal in front of her. Resident #16 was not eating her meal. Staff did not approach her to inquire about her meal or offer an alternate or substitute. At 5:25 pm, Resident #16 ate her chicken and her dessert, but did not eat her rice or her carrots. At 5:37 pm, CNA #3 removed Resident #16's plate from the table. CNA #3 stated, "Didn't you like your rice or carrots?" Resident #16 stated, "No." CNA #3 took Resident #16's plate and scraped the rice and carrots into a trash can. Staff did not offer Resident #16 a substitute starch or vegetable.

F 364 changes/substitutions in menu items.

Resident #16: Staff will inquire as to why resident is not eating her meal and offer a substitute which will be provide in a timely manner if desired. Resident will be given sufficient time to finish her meal.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

All other residents have the potential to be affected by the same deficient practice. The alternate menu choice will be substituted within 15 minutes of request. If substitutions are used more quickly than anticipated, SCNF staff will contact the Dietary Services Manager and/or Food Service Supervisor for larger quantities. Additionally, if residents decline the alternate menu choice, the refrigerator/cupboard are stocked with multiple other items to offer. Residents aren't limited to only the alternate menu choice.

What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur:

As noted in FTag 241, staff members will be assigned as dining room monitors and use a Dining Room Checklist listing all areas needing improvement. The
On 1/11/17 at 5:40 pm, CNA #3 stated as soon as the last resident in the First Street (first floor) dining room had been served a meal, the food was removed from the serve-out kitchen and taken to the Second Street (second floor) serve-out kitchen. CNA #3 stated to get a substitute meal for a resident, staff called the Second Street dining room to see if an alternate item was available, and if one was available, staff went upstairs and get it. CNA #3 stated it was an oversight that Resident #16 had not been offered a substitute for her starch and vegetable.

On 1/11/17 at 6:10 pm, the ADON stated if a resident requested a substitute meal after they were served, they had to wait until every resident had been provided their first choice of meal. The ADON agreed this delay could be up to 40 minutes or longer, if one of the first residents served requested a substitute meal.

On 1/12/17 at 11:45 am, the RD stated the primary challenge the facility faced was the remote location of the main preparation kitchen. The RD stated the facility did its best to anticipate how much of each the main and alternate meals to prepare and transport to the facility, and there was always plenty of food to serve everyone, even taking into account residents may change their minds after they had been served the meal they initially chose. The RD stated there was often only one dietary person assigned to plate meals in the serve-out kitchens, so if they ran out of either the main or alternate meal in the serve-out kitchens, it became logistically difficult to obtain additional food items timely. The RD stated the facility had implemented the practice of ensuring each resident had the opportunity to

checklist will also include: Alternate menu selection provided within 15 minutes of request; Additional items stored in the refrigerator/cupboard offered as substitutions; Dietary Service Manager and/or Food Service Supervisor contacted for larger quantities of alternate menu choice if needed; All Staff attentive, respectful and accommodating with changes/substitutions. Staff in-serviced 2/6/17, 2/7/17, 2/13/17 and 2/14/17.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

Six meals will be monitored each week (2 breakfast, 2 lunch, 2 dinner) x 2 weeks, then 3 meals weekly (1 breakfast, 1 lunch, 1 dinner) x 4 weeks to ensure compliance. Results reported at Quarterly QA Meetings.
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<tbody>
<tr>
<td>F 364</td>
<td>Continued From page 38</td>
<td>be served their &quot;first choice&quot; of available items before providing substitute meals for residents who had already been served.</td>
<td>F 364</td>
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<td>F 431</td>
<td>SS=E</td>
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**PROVIDER'S PLAN OF CORRECTION**

*EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY*

**SUMMARY STATEMENT OF DEFICIENCIES**

*(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)*

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

*(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:*

<table>
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<th>BUILDING</th>
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</table>

**STATEMENT OF DEFICIENCIES**

- F 364
  - Continued From page 38
  - be served their "first choice" of available items before providing substitute meals for residents who had already been served.

**DEFICIENCY**

- F 431
  - SS=E
  - 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

  - (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

  - (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

    - (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

    - (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

    - (g) Labeling of Drugs and Biologicals. 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...
### SUMMARY STATEMENT OF DEFICIENCIES

**F 431** Continued From page 39 applicable.

(h) Storage of Drugs and Biologicals.

(1) 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 have access to the keys.

(2) 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.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, it was determined the facility failed to ensure controlled drugs were secured and separately locked from other medications. This created the potential for unauthorized access to controlled drugs by residents, as well as, staff and other individuals. Findings include:

On 1/11/17, at 6:35 pm, during medication administration observations on the First Street resident care area, the medication cart was in a designated medication storage area with a locked door. The medication cart included a drawer that contained Controlled Schedule II drugs. The drawer was unlocked.

RN #2 who was administering medications during the observation period, confirmed the drawer was

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**F 431 DRUG RECORDS, LABELS/STORE & BIOLOGICALS**

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

No specific residents in the sample identified in this F-Tag.

How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

All residents have the potential to be affected. Medication nurses will ensure
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

135111

**Date Survey Completed:**

01/13/2017

**Name of Provider or Supplier:**

SYRINGA CHALET NURSING FACILITY

**Street Address, City, State, Zip Code:**

700 EAST ALICE STREET
BLACKFOOT, ID 83221

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 431</td>
<td></td>
<td>Continued From page 40 unlocked, and stated it should be locked at all times. On 1/12/17, at 2:00 pm, during medication administration observations on the Second Street resident care area, the medication cart was in a designated medication storage area with a locked door. The medication cart included a drawer that contained Controlled Schedule II drugs. The drawer was unlocked. LPN #2 who was administering medications during the observation period, confirmed the drawer was unlocked, and stated it should be locked at all times.</td>
<td>F 431</td>
<td></td>
<td>the drawers/Portable Lock Boxes (PLB) on the med cart that contain controlled drugs are secured and locked per the following policies: 231-13-400 Control and Administration of Medications B.1.c All medication areas and cabinets shall be kept locked at all times when the medication nurse is not present. 231-22-400 Dispensing and Accountability of Schedule II Unit Dose Medication II.A.7 The PLB should be kept locked inside the Medication Room and the box itself shall be locked with its key remaining in the possession of the Unit Medication nurse for the current shift. The only times that a PLB should be opened are: (a) medication administration time when the M.A.R. indicates a Schedule II med should be administered; (b) when the contents of the on-coming and out-going PLBs are to be simultaneously counted and verified by both the Pharmacy Delivery Representative and the Unit Medication Nurse. Nurses in-serviced 2/7/17, 2/13/17. Address what measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur: Pharmacy will determine compliance at cabinet exchange times (per frequency as noted below) by the Pharmacy Delivery</td>
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The policy and procedure for securing controlled substances include:

- **Control of Medications**
  - All medication areas and cabinets shall be kept locked at all times when the medication nurse is not present.
  - PLBs should be kept locked inside the Medication Room and the box itself shall be locked with its key remaining in the possession of the Unit Medication nurse for the current shift.
  - Only administered under the following conditions:
    - When the M.A.R. indicates a Schedule II med should be administered.
    - When the contents of the on-coming and out-going PLBs are to be simultaneously counted and verified by both the Pharmacy Delivery Representative and the Unit Medication Nurse.

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Address what measures will be put in place and what systemic changes will be made to ensure the deficient practice does not recur:

- **Pharmacy**
  - Determine compliance at cabinet exchange times (per frequency as noted below) by the Pharmacy Delivery Representative and the Unit Medication Nurse.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135111  
**Multiple Construction: A. Building:**  
**B. Wing:**  
**Date Survey Completed:** 01/13/2017

**Name of Provider or Supplier:** Syringa Chalet Nursing Facility  
**Address:** 700 East Alice Street, Blackfoot, ID 83221

### Summary Statement of Deficiencies

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<td>F 431</td>
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</table>

**F 431 Continued From page 41**

Representative checking to see if the drawers/PLB is secured and locked. If found unlocked, The Pharmacy Representative will immediately notify the SCNF Administrator and DNS.

How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained:

The Pharmacy Delivery Representative will conduct random checks 3 x weekly x 4 weeks to ensure the drawers/PLB are secured and locked. In addition, Syringa staff will conduct random checks on each shift 3 x weekly x 3 weeks, then 1 x weekly on each shift x 3 weeks. Results reported at Quarterly QA Meetings.

**F 441**

SS=E  
483.80(a)(1)(2)(4)(e)(f) Infection Control, Prevent Spread, Linens

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);
(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility’s IPCP and the corrective
### F 441 INFECTION CONTROL

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Residents #6, #8, #14, #15, and #16: All staff will consistently perform standard hand hygiene while assisting these residents in the dining room as it relates to assisting different residents with feeding, obtaining different food items/clothing protectors, clearing plates/utensils, touching the intercom, another piece of furniture/wheelchair, or another resident’s arm/hand etc. Proper hand hygiene will also be used when leaving and returning to the dining room and putting on/removing and disposing of gloves to prevent the development and transmission of disease and infection.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

### F 441

Continued From page 43 actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff consistently performed standard hand hygiene to reduce the risk for infection. This was true for 5 of 16 residents (#6, #8, #14, #15, and #16) observed while dining. This failure created the potential for residents to develop infection from cross-contamination. Findings include:

The facility's Hand Hygiene policy, last revised 8/11/16, documented, "Hand hygiene measures are the single most important prevention strategy for avoiding Healthcare Acquired Infections. The procedure for hand hygiene included washing hands and/or using Alcohol Based Hand Rub (ABHR) and when it was to be performed:

Hand Washing:

* Before and after eating or handling food.
* Before and after assisting a resident with meals.

ABHR:

*Between resident contacts if more than one
F 441 Continued From page 44

resident is in a room.

*Before donning and after removing gloves.

The policy was not followed. Examples include:

* On 1/11/17 at 5:20 pm, CNA #2 was in the First Street dining room assisting Resident #8 with her meal. At 5:24 pm, CNA #2 got up from the table, went to a cart to get a carton of chocolate milk, opened the container and poured it into Resident #15’s cup, then sat and resumed feeding Resident #8. CNA #2 did not don gloves or perform hand hygiene throughout this observation. At 5:30 pm, CNA #2 stood up from the table, took a clothing protector which had been laying in Resident #21’s lap, placed it around the resident’s neck, sat back down, and resumed feeding Resident #8. CNA #2 did not perform hand hygiene at any point during this observation.

* During an observation in the First Street dining room on 11/11/17 at 6:10 pm, CNA #2 was standing and feeding Residents #8 and #14, who were seated at two separate tables. She was observed to walk to an intercom on the wall, press a button, and speak to another resident. She left the intercom, rested her arm on a chair, and spoke with another resident. CNA #2 returned to Resident #8 and offered her some food. She went to Resident #14 and offered him some food. CNA #2 went to Resident #15 and touched her arm as she spoke with her. Resident #6 asked CNA #2 for some juice, and CNA #2 put her arm around Resident #6 then offered her juice from the refreshment room. CNA #2 continued to offer food to Resident #8. At 6:25 pm, CNA #2 left the dining room and returned at

All other residents in the facility have the potential to be affected by these faulty practices with staff failing to perform standard hygiene in the dining room.
Staff in-serviced 2/6/17, 2/7/17, 2/13/17, 2/14/17.

What measures will be put into place or what systemic change will you make to ensure that the deficient practice does not recur:

As noted in F241, a Dining Room Monitor will be assigned to the Dining room. Additional areas noted in this F-Tag related to hand hygiene will be included on the checklist.

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:

As noted in F241, Staff members will be assigned as dining room monitors and use a Dining Room Checklist listing all areas needing improvement including hand hygiene. A staff member will monitor the dining room 6 meals weekly (2 breakfast, 2 lunches and 2 dinners) x 2 weeks, then 3 meals weekly (1 breakfast, 1 lunch, 1 dinner) x 4 weeks to ensure compliance. Audit results reported at Quarterly QA Meetings.
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<tbody>
<tr>
<td>6:28 pm with Resident #16, and wearing gloves. Upon positioning Resident #16's wheelchair at a table, CNA #2 removed her gloves and held the used gloves in her left hand. CNA #2 assisted Resident #15 with finishing her food, then removed her plate and clothing protector. She placed the used gloves in her left pocket. Hand hygiene was not performed after she removed her gloves. CNA #2 went to Resident #14, cleared his plate, clothing protector and eating utensils. CNA #2 did not perform hand hygiene during the time she was observed in the dining room. She provided assistance with meals to multiple residents, touched residents, the intercom, wheelchairs and other furniture.</td>
<td>F 441</td>
</tr>
</tbody>
</table>