



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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3232 Elder Street
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February 1, 2018

Kim Gessford, Administrator
Syringa Home Training
1070 N Curtis Rd Suite 125
Boise, ID 83706

RE: Syringa Home Training

Dear Ms. Gessford:

This is to advise you of the findings of the Initial Medicare survey of Syringa Home Training, which was conducted on January 26, 2018.

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

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

Sincerely,

Nicole Wisenor RN on behalf of:

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

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

PRINTED: 01/31/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132532	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2018
NAME OF PROVIDER OR SUPPLIER SYRINGA HOME TRAINING			STREET ADDRESS, CITY, STATE, ZIP CODE 1070 N CURTIS RD SUITE 125 BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
V 000	<p>INITIAL COMMENTS</p> <p>[CORE]</p> <p>No deficiencies were cited during the initial Medicare certification survey of your dialysis unit, conducted from 1/25/18 - 1/26/18. Syringa Home Training is in compliance with the requirements of 42 CFR Part 494, Conditions for Coverage of End-Stage Renal Disease Facilities. The surveyors conducting the initial Medicare certification survey were:</p> <p>Trish O'Hara RN, HFS Team Lead Laura Thompson, RN, HFS</p>	V 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.